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*SECRETARY OF THE AIR FORCE*

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*Aerospace Medicine*

# *MEDICAL EXAMINATIONS AND STANDARDS VOLUME 2-ACCESSION, RETENTION, AND ADMINISTRATION*

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This instruction implements AFPD 48-1, *Aerospace Medical Program* and Department of Defense Directive (DoDD) 1332.18, *Separation or Retirement for Physical Disability*, and DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*, December 2000, DoDI, 6130.4, *Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces*, Jan 2005, DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*. It establishes procedures, requirements, recording, and medical standards for medical examinations given by the Air Force. It prescribes procedures and references the authority for retiring, discharging, or retaining members who, because of physical disability, are unfit to perform their duties. This instruction applies to all applicants for military service, scholarship programs, Air National Guard and the Air Force Reserve. Active duty flight medicine offices will use the Air Force Reserve Command (AFRC) supplement to this instruction when managing units assigned Reserve Members, and will maintain a copy of the AFRC Supplement when Reserve units are located on the same base.

This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Authority to collect and maintain records prescribed in this outlined in Title 10, United States Code, Section 8013 and Executive Order, 9397. Privacy Act System Notice F044 AFSG G, Aeromedical Information Management and Waiver Tracking System (AIMWTS), applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123, *Management of Records* and disposed of in accordance with the *Air Force Records Disposition Schedule (RDS)* located at **https://afrims.af.mil** The reporting requirement in this volume are exempt from licensing according to AFI 33-324, paragraph 2.11.10, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*. Send comments and suggested improvements on AF Form 847, *Recommendation for Change of Publication*, through channels, to AFMOA/SGPA, 110 Luke Avenue, Room 405, Bolling AFB, DC 20032-7050. **Attachment 1** is a list of references and supporting information.

# Chapter 1

## MEDICAL EXAMINATIONS FOR SEPARATION & RETIREMENT

**1.1. Policy.** Do not delay separation or retirement past scheduled date of separation or retirement to complete a medical examination unless medical hold is approved (see **Chapter 2**).

**1.2. Purpose.** To identify medical conditions requiring attention and to document current medical status to determine continued fitness for duty.

**1.3. Presumption of Fitness.** If performance of duty in the 12 months before scheduled retirement is satisfactory, the member is presumed to be physically fit for continued active duty or retirement, unless there is clear and convincing evidence to the contrary. (See AFI 41-210, *Patient Administration Functions* for presumption of fitness prior to separation)

**1.4. Law Governing Disability Evaluation.**

1.4.1. Title 10, United States Code, Chapter 61 provides for disability retirement and separation.

1.4.2. Title 38, United States Code administered by the Department of Veterans Affairs governs disability compensation for ratable service-connected defects that have not precluded active service.

1.4.3. Title 10, United States Code Sec 1145 directs conduct of separation examinations on specific individuals leaving the USAF.

**1.5. Mandatory Examinations.**

1.5.1. A medical assessment by a credentialed provider and documented on DD Form 2697 and supporting documents as outlined in paragraph **1.5.2.** is mandatory when:

1.5.1.1. Member has not had a Preventive Health Assessment (PHA) within one year. If transferring to ARC, an AF Form 422, *Physical Profile Serial Report***,** will be used to document the member's retention qualification. Members who are current on their PHA (within the 12 months preceding the actual date of retirement) will complete a DD Form 2697, from which the need for further evaluation will be determined.

1.5.1.2. Medical authority requires an examination to be done for either clinical or administrative reasons.

1.5.1.3. Separation is involuntary, or is voluntary in lieu of trial by court martial, or retirement in lieu of involuntary administrative separation.

**Exception:** Member is separated or retired in absentia.

1.5.1.3.1. If the member has had an initial enlistment/commissioning examination within the preceding 12 months, DD Form 2697 will be the only requirement.

1.5.1.4. A medical assessment with provider exam as outlined in **paragraph 1.5.2.** DD Form 2697, as a minimum, is required for members having had a PHA within one year of Air Force Personnel Center (AFPC) approved retirement date (no SF 88, *Report of Medical Examination*/DD Form 2808, *Report of Medical Examination* is required). The DD Form 2697 will be accomplished not earlier than 180 days prior to projected separation or retirement and not later than 30

days prior to projected separation or retirement. Exceptions to meet mission requirements or short-notice separation/retirement will be handled on a case-by-case basis and must include coordination with the Local Veteran's Administration Transition Officials if the member is expected to file a disability claim with the VA.

1.5.1.5. The member is tentatively approved by HQ AFPC for early separation from active duty and assignment into an ARC under PALACE CHASE, and the member's most recent medical examination (PHA) was completed more than 12 months ago at the time of application.

1.5.1.6. The member is tentatively approved by AFPC for early separation from active duty and assignment into the ARC under PALACE FRONT, and the member's most recent medical examination (PHA) was completed more than 12 months ago at the time of application.

1.5.1.7. The member's medical record has been lost. Accomplish Preventive Health Assessment with SF 93, *Report of Medical History*/DD 2807-1, *Report of Medical History* along with the DD Form 2697. Provider examination should address significant medical history and determine if qualification for continued service is questionable.

1.5.1.8. The member is a Repatriated Prisoner of War (Mil-PDS assignment limitation code 5, or 7). The evaluation will include a Review in Lieu of (RILO) MEB unless waived by HQ AFPC/DPAMM. Forward a copy of the examination to the addresses in AFI 48-123V3, paragraph 2.2.4.

1.5.1.9. Members of the reserve component separated from active duty to which they were called or ordered in support of a contingency and for whom the period of active duty exceeded 30 days. This includes ARC member's called/ordered to initial active duty for training (ADT), active duty, or Federal Service during times of contingency, conflict, or war.

1.5.1.10. Members separated from active duty who pursuant to voluntary agreement of the member to remain on active duty for less than one year, unless **1.5.1.3.1.** applies.

1.5.1.11. Members involuntarily retained on active duty in support of a contingency unless they have a current (within 12 months preceding the actual date of separation) PHA.

1.5.2. Medical Assessment (DD Form 2697). Members who require a separation examination IAW paragraph **1.5.1.** will complete, as a minimum, a medical assessment as described below. This assessment will be accomplished not earlier than 180 days of scheduled separation, retirement or beginning of terminal leave, and not later than 30 days prior to these events. (See paragraph **1.5.1.4.**)

1.5.2.1. The assessment should include:

1.5.2.1.1. A completed DD Form 2697 (see paragraph **6.5.**).

1.5.2.1.2. Clear documentation of any significant medical history and/or new signs or symptoms of medical problems since the member's last medical assessment/medical examination. See the last two sentences in Section II, DD Form 2697 for additional guidance.

1.5.2.1.3. An examination by a privileged health care provider. When appropriate/required, examinations will be done and results documented in section II, item 20 of DD Form 2697. The examination and studies will be those determined by the provider to be necessary to determine the examinee's continued qualification for worldwide service, evaluate significant items of medical history, or evaluate new signs and/or symptoms of injury or illness.

1.5.2.1.4. All personnel 35 years of age and older who are separating or retiring from the Air Force will complete screening for Hepatitis C.

1.5.2.2. File the completed DD Form 2697 in the medical record. If the medical record is not available, forward DD Form 2697 sealed, to the Separation and Retirements Section of the member's servicing Military Personnel Flight (MPF). File a copy of the form in the dental record if a dental problem was identified during the assessment. File all consultation reports with the DD Form 2697.

1.5.2.3. Forward copies of medical examinations/medical assessments accomplished on Air National Guard (ANG) (full-time ARG Title 31, EAD Title 10) members to HQ ARPC/DSFRA for retention as required by Title 10, United States Code, Chapter 8502.

1.5.2.4. Forward a copy of DD Form 2697 (ensure HIPAA compliance with signed authorization from the member) to the In-Service recruiter for all members entering an ARC through the PALACE CHASE/FRONT Programs.

1.5.2.5. HIV testing for separation or retirement is required only when deemed appropriate by the primary care manager (Consult AFI 48-135, *Human Immunodeficiency Virus Program*).

1.5.3. Termination Occupational Examinations. If required, accomplish termination occupational examinations during the separation or retirement examination/assessment (see **Chapter 7** on termination exams).

**1.6. General Officers.** Examinations for retirement should be conducted IAW AFI 36-3203, *Service Retirements*, Chapter 5.5.

## Chapter 2

## MEDICAL HOLD

**2.1. Purpose.** Administrative action retaining a member on active duty beyond an established date of separation or retirement. Consult AFI 41-210 for further guidance on Medical Hold authority and related topics.

2.1.1. Medical hold is not appropriate for members who are being involuntarily separated, except as directed by AFI 41-210.

2.1.2. Separation or retirement processing continues until medical hold is approved.

2.1.3. Medical hold does not apply to ARC members ending an active duty tour and returning to active ARC status.

**2.2. Requests.** Requests for medical hold may be coordinated by telephone with the attending physician contacting HQ AFPC/DPAMM directly for active duty personnel. Medical hold requests on ARC personnel will be coordinated with the appropriate ARC/SG. (AFI48-123V4 Attachment 2, note 8). The requesting physician should have the following information readily available:

2.2.1. Date of projected separation or retirement.

2.2.2. Whether MEB processing has been initiated.

2.2.3. Whether administrative or punitive discharge is pending.

2.2.4. Servicing MPF implementing separation or retirement.

2.2.5. A projected medical hold release date.

**2.3. Approvals.** HQ AFPC/DPAMM or the appropriate ARC/SG must receive the completed MEB no later than 30 days from the date of approval of the medical hold action.

**2.4. Disapproval.** Medical hold is not approved for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, civilian employment issues, elective surgery or its convalescence, other elective treatment of remedial defects, or for conditions that do not warrant termination of active duty through the Disability Evaluation System. (Refer to AFI 41-210)

2.4.1. Enlisted members cannot be forced to remain in service beyond their Expiration of Term of Service (ETS). They must agree in writing to a medical hold. Officers serve, “at the pleasure of the President.” and therefore, actions to place them on medical hold do not require their consent.

**2.5. Separation Dates.** Medical hold cannot be imposed after the date of separation or retirement has occurred. If an individual requires an MEB, medical hold should be requested at least 60 calendar days prior to retirement or separation date.

**2.6. Judicial Proceedings.** Members sentenced to dismissal or punitive discharge by a court martial, or who are under charges which may result in such sentences, are not eligible for MEB processing. Medical hold is not authorized unless court martial sentences are suspended, or court martial charges are dropped or vacated to permit separation or retirement in lieu of court-martial, or charges are held in abeyance

pending a sanity determination. Refer to AFI 36-3212, *Physical Evaluation for Retention, Retirement or Separation*, paragraphs 1.3., 1.4., 1.5., and 1.10.

**2.7. Separation or Retirement.** Members having orders for separation or retirement due to disability, who experience a significant clinical change before actual release from active duty, require revocation of orders and reprocessing of MEB. The servicing Medical Treatment Facility (MTF) contacts HQ AFPC/DPPDS (Disability Processing Division).

## Chapter 3

## MEDICAL STANDARDS

### 3.1. Medical Evaluation for Continued Military Service (Retention Standards):

3.1.1. Scope. **Attachment 2** establishes medical conditions and defects that may preclude continued military service and require Medical Evaluation Board (MEB) processing. It incorporates guidelines in DoD Directive 1332.18, *Separation or Retirement for Physical Disability*. See also AFI 41-210, *Patient Administration Functions*. **Attachment 2** establishes medical conditions and defects that may preclude continued military service and require MEB or ARC Fitness for Duty (FFD) Worldwide Duty, (WWD) processing.

3.1.2. Applicability. The retention standards in **Attachment 2** apply to:

3.1.2.1. Regular Air Force members on active duty, unless excluded from disability evaluation by applicable directives (e.g. Punitive actions).

3.1.2.2. All individuals who have separated or retired from active duty with any of the regular Armed Services, but who are reenlisting in the regular Air Force or ARC when no more than 6 months have elapsed between separation and reenlistment.

3.1.2.3. ARC and retired regular members if mobilized or otherwise recalled to active duty.

3.1.2.4. ARC members who are:

3.1.2.4.1. On EAD unless excluded from disability evaluation by applicable directives.

3.1.2.4.2. Involuntarily ordered to EAD with the regular Air Force and who are eligible for fitness evaluation under applicable directives.

3.1.2.4.3. Reenlisting in the regular Air Force when no more than 6 months have elapsed between release from EAD with any regular Armed Service and reenlistment or entry. If more than 6 months have elapsed, **Attachment 3** applies.

3.1.2.4.4. Not on EAD but eligible for MEB under applicable directives.

3.1.2.4.5. AFRC members entering Active Guard Reserve (AGR) tours. ANG members entering EAD statutory tours (Title 10) or AGR tours (Title 32).

3.1.2.5. United States Air Force Academy (USAFA), Air Force Reserve Officer's Training Corps (AFROTC) cadets and Health Professions Scholarship Program (HPSP) when the student begins their third academic (USAFA Second Class) year.

3.1.3. Air Reserve Components. The appropriate ARC surgeon (see AFI48-123V4 Attachment 2, note 8) uses the standards in **Attachment 2** either alone or in combination with other criteria to determine:

3.1.3.1. The medical qualification for continued military duty in the ARC for members not on EAD and not eligible for disability processing.

3.1.3.2. The medical qualification of officers and enlisted members from any service component requesting entrance into USAFR and ANG.

3.1.3.2.1. The medical qualification of officers and enlisted members from any service component requesting entrance into the ANG provided no more than 6 months have elapsed between separation from the service component and entry into the ANG.

3.1.3.2.2. If more than 6 months (from date of separation) have elapsed, applicants must meet the standards of **Attachment 3**.

**3.2. Medical Standards for Appointment, Enlistment, and Induction:**

3.2.1. Scope. **Attachment 3** establishes basic medical standards for enlistment, appointment, and induction into the Armed Forces of the United States according to the authority contained in Title 10, United States Code, Section 113. It implements DoD Directive 6130.3, *Physical Standards for Appointment, Enlistment and Induction.* These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the medical judgment of the examining healthcare provider.

3.2.2. Applicability. These standards apply to:

3.2.2.1. Applicants for appointment as commissioned officers in the Active and Reserve components who have not held a prior commission for at least 6 months, or it has been more than 6 months since separation.

3.2.2.2. Applicants for enlistment in the regular Air Force. Medical conditions or physical defects predating original enlistment, for the first six months of active duty in the regular Air Force.

3.2.2.3. Applicants for enlistment in the Reserve or Air National Guard. For medical conditions or physical defects predating original enlistment (existing prior to service (EPTS)), these standards apply during the enlistee's initial period of active duty for training until their return to their Reserve Component Units.

3.2.2.4. Applicants for reenlistment in Regular Air Force and ARC after a period of more than 6 months have elapsed since separation.

3.2.2.5. Applicants for the Scholarship or Advanced Course ROTC, and all other Armed Forces special officer personnel procurement programs.

3.2.2.6. Retention of cadets and midshipmen at the United States Air Force Academy and students enrolled in the ROTC scholarship programs, who have not completed 2 years with no break of their respective program.

3.2.2.7. AFROTC graduates whose active duty is delayed under applicable directives.

3.2.2.8. All individuals being inducted into the Armed Forces.

3.2.2.9. Individuals on Temporary Disability Retirement List (TDRL) who have been found fit upon reevaluation and wish to return to active duty. The prior disabling defect or defects, and any other physical defects identified before placement on the TDRL that would not have prevented reenlistment, are exempt from this directive.

***NOTE:*** Individuals on TDRL are considered "retired" and thus have left active duty, (most likely for a period of at least 6 months before their first re-examination as a TDRL designated member, and therefore, fall under accession standards (**Attachment 3**) prior to re-entering military service.

3.2.3. Rejection. **Attachment 3** sets forth the medical conditions and physical defects that are causes for rejection for military service.

3.2.4. Personnel rejected for military service for any medical condition or physical defect listed in **Attachment 3** may be reviewed if the condition has resolved and a history of the condition is not disqualifying IAW this AFI.

3.2.5. It is DoD policy under DoD Directive 6130.3, *Physical Standards for Appointment, Enlistment, or Induction, December 15, 2000* to utilize the International Classification of Disease (ICD) in all records pertaining to a medical condition that results in a personnel action, such as separation or medical waiver. In addition, when a medical condition standard is waiver or results in a separation, written clarification of the personnel action should be provided using standard medical terminology.

3.2.6. The standards in this Instruction shall be for the acquisition of personnel in the programs in **3.2.2.** above.

## Chapter 4

## PROFILES & DUTY LIMITATIONS

**4.1. Purpose.** This chapter, with AFI48-123V4, Attachment 3 and AFI48-123V4, Attachment 4, establishes procedures for the documentation and administrative management of members with duty limitations and occupational restrictions. These procedures have been developed to ensure maximum utilization and readiness of personnel, while preserving their health and preventing further injury or illness. When individuals have medical conditions affecting their continued qualification for retention in the Air Force, as outlined by the standards in **Attachment 2**, this chapter also describes appropriate courses of action for medical board disposition.

4.1.1. Healthcare providers should consult with supervisors and commanders to maximize use of the personnel on profiles. An operational risk management based assessment of personnel assigned to a squadron/unit is key to maintaining unit readiness to the highest degree possible.

4.1.2. The goal is that appropriate medical recommendations are communicated to commanders so they are able to determine the optimum utilization of members in their charge within the guidelines of the medically imposed restrictions.

4.1.3. Purpose of AF Form 422, *Physical Profile Serial Repor*t. When a member's health, safety and well being, mission safety or abilities to effectively accomplish the mission are at risk, providers must convey this information to the commander. The AF Form 422 is the means to accomplish this task.

4.1.3.1. Communicates information on the specific occupational duty limitations of military members. For detailed instruction for completing AF Form 422, see AFPAM 48-133, *Physical Examination Technique*s.

**4.2. Physical Profile System.** The physical profile system classifies individuals according to physical functional abilities. It applies to the following categories of personnel:

4.2.1. Applicants for appointment, enlistment, and induction into military service.

4.2.2. Active and ARC military personnel.

**4.3. Establishing the Initial Physical Profile.** The initial profile is established during the entry physical examination based on the results of that exam. The initial AF Form 422 verifies the initial profile serial of all individuals entering active duty and serves as the baseline AF Form 422. Primary Care Manager (PCM) (Flight Medicine for the ARC) in conjunction with Public Health will review the physical profile entered on the initial SF 88/DD Form 2808 and enter any revisions on the baseline AF Form 422. This should be performed at the first location of entry into the Air Force (i.e., Basic Military Training, Officer Training School), or at the first permanent duty station.

**4.4. Responsibilities:**

4.4.1. Air Force Health Care Providers.

4.4.1.1. All providers should be familiar with this chapter and **Attachment 2**, and AFI48-123V4, Attachments 3, 4 and 5 prior to recommending any profiling actions.

4.4.1.1.1. Clinical profiling actions should be monitored through the facility peer review program (see AFI 44-119, *Clinical Performance and Improvement*).

4.4.1.2. When necessary, the provider should communicate directly with the patient's supervisor to appreciate the patient's unique work environment or mission requirements when formulating limitations on a member that may affect a squadron's overall mission.

4.4.1.3. Providers should convey to commanders the necessary information to make informed decisions on the management of people in their charge. Since the member's commander is ultimately responsible for their personnel, the profile needs to be timely, accurate, and unambiguous to help commanders make the best decisions for their personnel and mission.

4.4.1.4. Providers and Primary Care Manager (PCM) team personnel will review existing profiles during all standard and special purpose medical examinations, or Preventive Health Assessments.

4.4.1.4.1. If a member fails to comply with medical assessment requirements and because of the member's failure to comply, the Air Force Medical Service cannot determine a member's current medical status; clearance actions for deployment, permanent change of station (PCS), retraining or attendance at service academies or Professional Military Education (PME) will be deferred until a new profile can be established.

4.4.1.5. Providers must ensure patients are aware of their responsibilities IAW paragraph **4.4.3.**

4.4.1.6. Providers will assist Public Health and Health Technicians in the ANG in accomplishing monthly reviews IAW paragraph **4.4.2.2.** by reviewing and co-signing the monthly review performed by Public Health. (This review is critical in cases where the care being rendered may lie outside the MTF. An example of this would be pregnant members who receive their OB/GYN care at a referral facility.) PCMs help to ensure deferrals or restrictions from full duty, deployment, or PCS are upgraded when no longer medically indicated.

4.4.1.7. Providers will also assist Public Health by making assignment or deployment recommendations for their patients on profiles. Conditions that may render a member at risk must be fully explored with the concurrence of the MDG Profile Officer (*EXAMPLE*: direct communication with a patient's commander may reveal specific duty limitations not previously documented).

4.4.1.8. When an assignment is pending (confirmed by MPF), the health care provider provides the restrictions to HQ AFPC/DPAMM, Randolph AFB, TX if it is determined that the individual is unable to PCS due to profiling actions. Disclosure of protected health information (PHI) should be IAW the 1996 Health Insurance Portability and Accountability Act (HIPAA) and AFI 41-210.

4.4.1.9. Providers will ensure that patient visits are appropriately documented in the medical record and that profile data is entered into the Preventive Health Assessment and Individual Medical Readiness (PIMR)/Reserve Component Periodic Health Assessment (RCPHA) software program or equivalent program.

4.4.1.10. Mental Health providers communicate with commanders IAW AFI 44-109, *Mental Health and Military Law.*

4.4.2. Public Health (Flight Medicine for the ARC; Health Technician for the ANG).

4.4.2.1. Public Health will manage the profiling system in accordance with this instruction. Public Health will serve as the communications link between squadron/unit commanders, supervisors, and the health care providers (to include the MTF/SGP (see below)).

4.4.2.2. Accomplish a monthly review and reconciliation with the Military Personnel Data System (MilPDS) and Preventive Health Assessment, Individual Medical Readiness (PIMR) for all personnel on Assignment Availability Codes (Code 31, Code 81 and Code 37) to include all active duty pregnancy profiles (Code 81) as well as all profiles recommending deferrals from deployment, PCS, or mobility consideration without the anticipation of an MEB (Code 31). Additionally, profiles for members undergoing Medical Evaluation Boards (MEB) will be monitored monthly until a disposition is obtained (Code 37). Public Health (PH) will coordinate with PCM teams and collaboratively validate the need to continue patients on 4T profiles on not less than a monthly basis. PH will send each PCM a list of their enrolled patients on the 4T roster every month, in order for the PCM team to update the profile, as required. Public Health will provide the MPF with a monthly update for each 4T patient.

4.4.2.2.1. Pregnancy profiles must be reviewed by the clinic providing primary care to the patient. Any changes in restrictions must be referred to Public Health. Refer to AFRC 48-101 for profiling guidance on pregnant reserve members.

4.4.2.2.1.1. The medical record shall be reviewed to ensure that care rendered outside of the primary care element has been evaluated and appropriate standards applied.

4.4.2.2.2. Public Health notifies the health care provider to initiate MEB action (FFD or WWD action for ARC members with non-duty related medical conditions) as soon as the provider determines that the member will not be expected to return to duty within 1 year of the 4T start date (or within 1 year of the date a 4T profile should have been initiated).

**Exception:** See paragraph **4.8.7.**

4.4.2.2.3. HQ AFPC/DPAMM is the final approval authority for exception to policy for Assignment Limitation to Code C on active duty members. Refer to AFI 41-210 for further guidance.

4.4.2.3. Ensure AF Forms 422 is appropriately accomplished by PCMs. A minimum quality review must be accomplished utilizing MTF acceptable and approved practices. Public Health is responsible for timely execution, and follow-up. Questions on applicability of standards versus restrictions may be addressed with either the provider, the Profile Officer or the SGP.

4.4.2.4. Public Health will review and sign the following profile actions:

4.4.2.4.1. Medical Evaluation Board action/disposition on AF Form 422 when a member is returned to duty and in accordance with HQ AFPC/DPAMM or ARC/SGP recommendations.

4.4.2.4.2. Medical Disqualification from an Air Force Specialty Code (AFSC) and subsequent retraining clearances.

4.4.2.4.3. Voluntary retraining profiles.

4.4.2.4.4. Recommendations to defer from deployment or PCS/Temporary Duty (TDY).

***NOTE:*** Unless noted in AFMAN 36-2105, *Officer Classification* or AFMAN 36-2108, *Enlisted Classification*, the ability to deploy is NOT a requirement to hold an AFSC or serve in any component of the USAF. Unless expressly stated in these instructions, medical disqualification from an AFSC may not be based on a member's ability or inability to deploy.

4.4.2.4.5. Recommendations to allow wear of non-uniform clothing (or deviations in uniform wear).

4.4.2.4.6. Pregnancy Profiles.

4.4.2.4.7. Profiles reporting serious medical conditions (i.e., restrictions that prevent mobility for 60 days or more) that may ultimately lead to MEB action.

4.4.2.4.8. Profiles accomplished after MEB/Physical Evaluation Board (PEB) action.

4.4.2.4.9. "4-T" Profile actions and removal thereof.

4.4.2.4.10. Profiles that resulted after direct provider/profile officer communication with unit commander or authorized party to restrict persons from specific duty requirements.

4.4.2.4.11. Permanent Change of Station or other assignment deferral.

4.4.2.4.12. Special Duty Assignment and Academy or Formal PME course applications/clearances.

4.4.2.4.13. Other profile actions as directed by the MTF/SGP (senior profile officer).

4.4.2.5. Public Health will distribute AF Form 422 as directed in this instruction. Care should be taken to ensure that distribution of a patient's PHI is limited to the minimum necessary and these disclosures must be tracked using local MTF procedures.

4.4.2.5.1. Commanders must know the fitness for duty status of the people in their charge. The HIPAA Privacy Rule allows for disclosures of PHI to commanders without the patient's authorization, but currently these disclosures must be tracked. Refer to AFI 41-210, paragraph 2.5.6. for more information on commander access to medical information. Refer to paragraph 2.2.3.5. for instructions on accounting for disclosures, and paragraph **4.5.** for instructions on how to accomplish the AF Form 422.

4.4.2.5.2. One copy of the profile will be given to the individual before they depart the MTF. One copy must be sent to the individual's unit commander. One copy will be sent to the MPF for all retraining, "4" (removal from and for profiles lasting more than 60 calendar days), formal school and PME.

4.4.2.6. Public Health will accomplish an initial medical record and PIMR review for incoming personnel to ensure any limitations to duty performance, TDY, deployment/mobility and PHA data are appropriately captured. Public Health will refer profiles suspected to be inappropriate, no longer necessary, or otherwise in need of correction or amendment to the profile officer to ensure mission effectiveness and patient safety are maintained. Questionable profiles will also be made available to the provider to determine in consultation with the individual's commander acceptable duty restrictions.

4.4.2.7. Retraining applications will be reviewed by Public Health to ensure members are qualified for entry into the AFSC(s) for which the member is applying. Review of each AFSC's physical requirements is found in AFMAN 36-2108, and AFMAN 36-2105. The AF Form 422 will indicate each of the selected AFSCs the member is, and is not qualified to enter. When flying or special operational duty AFSCs are selected, AFI48-123V3 Attachments 3, 4 **and** 5 will be reviewed for disqualifying defects. If defects are found, the member will be informed and a determination of potential waiver action will be determined by a flight surgeon.

4.4.2.8. Public Health will review profiles for members on selection for assignment to overseas, remote/isolated CONUS, or combat zones assignment. See AFI48-123V3 paragraph A5.9, Remote or Isolated Duty.

4.4.2.9. On return to duty following MEB/PEB action. Physical Evaluation Board Liaison Officers (PEBLO) will refer patients to Public Health following a PCM review of HQ AFPC/DPAMM recommendations to establish the new serial profile.

4.4.3. Members of the Active Duty and Reserve Components.

4.4.3.1. Responsible for ensuring their units are apprised of their current medical and physical status.

4.4.3.2. When limitations affecting deployability, assignability (PCS/TDY), or performance of required duty are determined, the member is responsible for ensuring the information is made available to appropriate personnel in their direct chain of command.

4.4.4. Profile Officers.

4.4.4.1. Profile officers are appointed by letter by the MTF Commander.

4.4.4.1.1. The standards experts in the AFMS are graduates of the Residency in Aerospace Medicine (RAM). Where a RAM is assigned, he/she will serve as the primary or senior profiling officer when more than one profile officer is appointed by the MTF Commander.

4.4.4.1.2. At MTFs where a RAM is not assigned, or the sole RAM is a squadron or group commander, the MTF/CC will appoint the physician most knowledgeable in physical standards as the profile officer.

4.4.4.2. Profile officers will be familiar with this AFI and in particular, this chapter as well as **Attachment 2**, AFI48-123V3 Attachments 2, 3, 4 and 5, and AFI48-123V4 Attachments 3 and 4.

4.4.4.3. Profile officers will ensure squadron interests (mission) and the patient's interests (health or restoration of health) are considered to maximize the benefit to both.

4.4.4.4. The Senior Profile Officer will consult with MAJCOM/SGPA when conflicts between patient interest and commander interest cannot be resolved locally. If there is a risk to the patient that the senior profile officer believes may not be fully realized by the unit commander, the wing commander will have the final authority to resolve the issue(s) of both parties.

4.4.4.5. The Profile Officer performs final review and signs all AF Forms 422 recommending:

4.4.4.5.1. Medical Evaluation Board action.

4.4.4.5.2. Medical Disqualification from an AFSC and recommended retraining. Voluntary retraining or retraining for other than a medical cause does not require a profile officer signature.

4.4.4.5.3. Recommendations to defer from deployment or PCS/TDY.

4.4.4.5.4. Recommendations to allow wear of non-uniform clothing (or deviations in uniform wear).

4.4.4.5.5. Pregnancy Profiles.

4.4.4.5.6. Profiles reporting serious medical conditions that may ultimately lead to MEB action.

4.4.4.5.7. Profiles accomplished after MEB/PEB action.

4.4.4.5.8. Profiles that resulted after direct communication with unit commander or authorized party to restrict persons from specific duty requirements.

4.4.4.5.9. Permanent change in profile number.

4.4.4.5.10. All AF Forms 422 reviewed for direct entry from active duty into any AF Commission Programs (i.e. Officer Training School (OTS), AF ROTC or Airman Education Commissioning Program).

4.4.4.6. Healthcare providers are required to initiate unit command consultation; profile officers will only review to ensure applicable instructions as outlined in this AFI are met.

4.4.4.7. Profile officers may supersede the recommendations of a healthcare provider only after consultation with the recommending physician. In cases where there is disagreement on profiling issues, the senior profile officer will make the final determination after review of the records and, when necessary, consulting with the unit commander.

4.4.4.8. Profile officers must notify MAJCOM/SG when a general officer receives a 4T profile.

4.4.5. Military Personnel Flight (MPF).

4.4.5.1. Serves as a key partner to many aspects of the profile system. Works with Public Health to ensure actions are accomplished in a timely fashion to minimize lost duty time for members and the units to which they are assigned.

4.4.5.2. Provides Public Health with lists of potential AFSCs when members are seeking to retrain into a new AFSC.

4.4.5.3. Ensures Public Health is part of the process in clearing applicants for special duty assignments, PME, formal schools clearance, medical retraining requests, overseas PCS clearances, security clearances (see AFI 36-2104 for specific procedures on PRP/SCI clearances).

4.4.5.4. Processes retraining requests as a result of medical recommendations.

4.4.5.5. Request and process overseas PCS clearance based on medical recommendations.

4.4.5.6. Provides a monthly listing of personnel with Assignment Availability Codes of 31, 37, and 81 from MilPDS to Public Health.

4.4.5.7. Ensures effective processes are established between the MPF and Public Health for reconciling 4T profiles between MilPDS and PIMR.

4.4.6. HQ AFPC/DPAMM.

4.4.6.1. Reviews all local MEB actions and Review In-Lieu-of (RILO) MEB case submissions.

4.4.6.2. Authorizes medical hold and informs servicing MPF, the member's MAJCOM/SG, and HQ AFPC/DPMARR/DPMARS/DPPDS/DPMRAS2.

4.4.6.3. If member is qualified for continued active duty, HQ AFPC/DPAMM returns the approved medical evaluation report to the medical facility with instructions for disposition of the examinee.

4.4.6.4. Refers to Physical Evaluation Board (PEB) all cases in which qualifications for retention are questionable.

4.4.6.5. Enters Assignment Limitation Code-C (ALC-C) for individuals returned to duty by PEB who are not medically suitable for global deployment or PCS assignment limitation.

***NOTE:*** ARC members will have their ALC-C established through the applicable SG office (see paragraph **4.4.7.3.**)**.**

4.4.6.6. Establishes requirements for periodic reevaluation of all individuals with ALC-C.

4.4.6.7. For members currently overseas or for members with an overseas assignment pending, all Assignment Limitation Code-C cases must be coordinated with AFPC/DPAMM.

4.4.7. ARC Surgeon.

4.4.7.1. Reviews all MEBs and RILO MEBs on all AFRC members eligible for disability processing prior to forwarding to HQ AFPC/DPPDS.

4.4.7.1.1. If member is qualified for continued military service, ARC/SGP returns the approved medical evaluation report to the ARC medical unit and MTF with instructions for disposition of the examinee.

4.4.7.1.2. Refers directly to HQ AFPC/DPPDS all cases in which qualification for retention are questionable and when PEB review is recommended by the local MTF.

4.4.7.2. Determines medical qualification for continued military duty on ARC members with questionable or disqualifying medical conditions who are not eligible for disability processing.

4.4.7.3. Assigns ALC-C code to Reserve members and ANG/SG assigns DAC-42 code to ANG members with coordination with ANG/DP. (see paragraph **3.1.3.**).

4.4.8. HQ AFPC/DPPDS.

4.4.8.1. Reviews all appeal cases of ARC members who are pending separation for a non-duty related impairment or condition. Members will enter the DES for a determination of fitness only.

4.4.8.2. Notifies all appropriate agencies of the PEB decision and provides disposition instructions. (See AFI 36-3212 for further guidance).

**4.5. Accomplishing AF Form 422, Individual Medical Recommendation and Profile Serial Report -This section describes how the revised AF Form 422 is completed.**

4.5.1. Patient Demographics.

4.5.1.1. The member, healthcare provider, PCM support personnel, or FHM personnel may complete form. Each block requires information. If that information does not exist, such as an e-mail address, the block should be dashed to indicate it was not omitted. Software that automatically populates this data is recommended when available.

4.5.2. Risk-Based Disposition.

4.5.2.1. A series of check boxes detailing the recommended action(s) following a diagnosis that may limit a member's overall status. This section is checked by the healthcare provider, or in the case of medical clearance actions, Public Health (in consultation with a profile officer when appropriate).

4.5.2.2. The healthcare provider must perform Duty Profile changes. Signature of the profile officer is also required in these cases. In cases where there is disagreement between the healthcare provider and the profile officer see paragraph **4.4.4.7.**

4.5.3. Special Purpose Medical Clearance.

4.5.3.1. A series of check boxes detailing the recommended action(s) following a diagnosis that may limit a member's overall status. This section is reviewed and completed by the healthcare provider, or in the case of medical clearance actions, Public Health (in consultation with a profile officer when appropriate).

4.5.4. Healthcare Provider Comments.

4.5.4.1. This section provides a space for written comments regarding a member's physical limitations and recommended restrictions due to a condition that may limit performance.

4.5.4.2. Comments must be legible.

4.5.4.3. Comments may be continued on reverse side of form.

4.5.4.4. This section should not include physical conditions, defects, or diagnoses in either medical or layman's terms. Disclosure of PHI should be IAW 1996 Health Insurance Portability and Accountability Act (HIPAA) and AFI 41-210.

4.5.4.5. The provider may revise comments about limitations or recommended restrictions in the event changes are necessary after consultation with profile officer, unit commander, or following a recommendation by Public Health. If revision of original restrictions is made, a full account of the circumstances surrounding the changes will be documented in the member's medical records.

4.5.4.6. Expiration date of restrictions must be specified.

4.5.4.7. Provider must include two statements in REMARKS section of AF Form 422 for any member with an OCONUS assignment. These are:

"I certify that the member's medical records were reviewed and the individual was seen by his/her PCM provider and no disqualifying conditions were found IAW AFI 48-123." (Must be signed by member's PCM.).

"I certify that the member's Life Skills/ADAPT/Family Advocacy records were reviewed and member was cleared for PCS IAW AFI 41-210 to a forward operating base." (Must be signed by a privileged mental health provider).

***NOTE:*** When profiles (or adjustments) are required after a specialty consultation, the referring PCM provider will be responsible for ensuring profiles are updated according to specialist(s) recommendations and the standards set in this AFI.

4.5.5. Physical Training and Fitness Testing.

4.5.5.1. Physical Training. Providers must use this section to specify medical restrictions and recommendations for physical training.

4.5.5.1.1. Restrictions from physical training should be indicated on a temporary profile and include an expiration date.

4.5.5.1.2. Fitness testing restrictions do not automatically exclude member from participating in a physical training program. Providers (PCMs) must provide exercise recommendations for

physical training. Member may also be referred to the Health and Wellness Center or physical therapy for fitness program consultation.

4.5.5.2. Fitness Testing. Providers use this section to specify fitness testing restrictions.

4.5.5.2.1. If no restrictions, then check the top block, "No restrictions."

4.5.5.2.2. If a member is restricted from completing any component(s) of the fitness test, the appropriate block(s) should be checked and provider must ensure compliance with AFI 10-248, *Fitness Program*.

4.5.5.2.3. The Fitness Test consists of four components as noted on the AF Form 422. Individuals who are able to perform their primary duties but are unable to complete one or more parts of the fitness evaluation do not require an MEB unless the underlying condition is listed in **Attachment 2**. Medical exemptions will last no longer than one year with the exception of pregnancy IAW AFI 10-248, paragraph 4.2.6.1. If the condition is permanent and interferes with the ability to deploy (see AFI48-123V4, Attachment 5) MEB action can be initiated if the commander and the provider feel that it is prudent.

4.5.6. Profile Serial Update.

4.5.6.1. This section is only used for initial, first assignment profile reviews, entry to new components, return to duty following an MEB/PEB, to effect a temporary disqualification for retention, permanent change in profile serial numbers, or for retraining. When accomplished, the provider, Public Health or Profile Officer, may fill it in.

4.5.6.2. When not used, "THIS SECTION NOT USED" block will be checked.

4.5.6.3. Refer to AFI48-123V4, Attachment 5 and AFI48-123V4, Attachment 6 for descriptions of the "PULHES" sections and appropriate entries for each letter.

4.5.6.4. "Suffix" Block. There are three allowable suffixes for this block.

4.5.6.4.1. "W" indicates member is qualified for retention in the USAF IAW standards outlined in **Attachment 2** of this instruction.

4.5.6.4.2. "T" indicates a member is temporarily not qualified for retention or is undergoing an MEB to determine fitness.

4.5.6.4.2.1. The "T" suffix may only be used in conjunction with a "4" profile in any of the PULHES categories.

4.5.6.4.2.2. A "T" suffix is not permanent and may not be imposed for more than 12 months without MEB/PEB action. Medical conditions requiring a profile are cumulative in nature (excluding conditions that are unrelated). Even when profile periods are intermittent, the sum of all profile time periods for the condition are totaled to determine the cumulative days.

4.5.6.4.2.3. A "T" suffix precludes deployment.

4.5.6.4.2.4. A "T" suffix precludes overseas PCS assignment until the condition is resolved, or member is returned to duty following MEB/PEB.

***NOTE:*** Refer to DoDI 1342.19, *Family Care Plan* for guidance regarding potential 4-month non-medical deferment from PCS, TDY and/or deployment (see AFI 36-2110, *Assignments*, paragraph 2.39.4). Do not include this time in profile expiration date. This is an administrative notification for commander only.

4.5.6.4.3. An “L” suffix is utilized when personnel are on Limited Assignment Status. This suffix is rare and may be used, or assigned to, AF personnel only by HQ AFPC/DPA.

4.5.6.5. Strength Aptitude Test (SAT) is used to determine if members applying for retraining or special duty meet minimum strength requirements.

4.5.6.5.1. General Information:

4.5.6.5.2. AFMAN 36-2108, *Enlisted Classification,* and AFMAN 36-2105*, Officer Classification* establishes a SAT standard for each AFSC.

4.5.6.5.3. When MPF requests a SAT evaluation in writing, Public Health reviews the accession Military Entrance Processing Station (MEPS) physical and completes the appropriate endorsement.

4.5.6.5.4. If the profile "X" factor equals or exceeds the SAT standard for the retraining AFSC, do not retest unless a medical condition is discovered changing the SAT. If a medical condition is discovered, refer the individual to a health care provider for evaluation prior to SAT testing. See AFMAN 36-2108, *Enlisted Classification,* and AFMAN 36-2105*, Officer Classification* for detailed requirements.

4.5.6.5.5. If the profile "X" factor is blank, contains a numeric character 1, 2, or 3, or is an alpha character less than the SAT standard, the SAT results are unsatisfactory.

4.5.6.5.6. Provider’s review of records indicates no potential medical reason that member cannot perform safe successful lifting attempt.

4.5.6.5.7. Refer member to the Fitness Center (gym) for administration of the SAT.

***NOTE:*** AFI 36-2626, Airman Retraining Program, outlines additional MPF responsibilities and contains a copy of the SAT requesting letter mentioned above.

4.5.6.6. “Previous.” The profile serial (numbers in PULHES) that was in effect prior to accomplishing current form.

4.5.6.7. “Revised Temporary.” The profile serial (numbers in PULHES) that went into effect as a result of the current medical conditions. (May not use “W” suffix with temporary revisions. Use a “T” suffix as described above in paragraph **4.5.6.4.** NOTE: Only “4” can be used with a “T.”

***NOTE:*** For restrictions that do not preclude deployment and are expected to resolve within 60 days, a change in profile series is not necessary.

4.5.6.8. “Revised Permanent.” The profile serial recommended by the profile officer or health care provider following resolution of a condition, MEB/PEB, Preventive Health Assessment or other occasions of care that mandates adjustments to the original profile.

4.5.7. Release Information and Patient Signature.

4.5.7.1. This block is signed by the patient to release the information without MTF tracking as required by HIPAA. Not signing this block does not prevent the MTF from providing information

to necessary command authorities; however, it does require tracking IAW AFI 41-210, paragraph 2.2.3.5.

4.5.8. Signature Blocks.

4.5.8.1. Provider signature required on all profiles initiated by healthcare providers.

4.5.8.2. Public Health (or Health Technician for ANG) signature required on all profiles as outlined in paragraph **4.4.2.**

4.5.8.3. Profile Officer signature required on all profiles as outlined in paragraph **4.4.4.**

4.5.9. Additional Comments Block.

4.5.9.1. This section may be used to further explain any other block or item, continue provider comments, add profile officer comments, or further define the profile's objective to communicate with squadron/unit commanders.

4.5.10. Code Blocks.

4.5.10.1. These blocks delineate the three assignment availability codes (Code 31, Code 81, and Code 37) and provide a location for any assignment limitation code C designation with a definition of each and the actions necessary when one of these codes is applied to an individual. This information must be entered on the front of the form as well.

4.5.10.2. These blocks should be marked as appropriate. Enter additional restrictions when indicated e.g. pregnant personnel with additional restrictions related to occupational exposures.

4.5.10.3. If appropriate, the PEBLO contact information will be provided.

4.5.11. Additional Contact and Release Information.

4.5.11.1. Provides additional contact information for Public Health, Flight Medicine Clinic, and the Family Practice Clinic or other provider.

4.5.11.2. Information for these blocks is provided by PCM support or Public Health and is there primarily to facilitate communication between the commander and the medical staff.

4.5.12. Disposition Information.

4.5.12.1. Lists locations where a copy of the AF Form 422 must be sent.

**4.6. Other Considerations.**

4.6.1. ARC members placed on Assignment Limitation Code-C or Deployment Availability Code-42 will be appropriately profiled and reevaluated IAW guidance from the appropriate ARC Surgeon.

4.6.2. A 4T profile temporarily disqualifies ARC members from military duty and precludes them from military participation in unit training assemblies (UTA), annual tours, or any other type active duty tour until the profile is removed. **EXCEPTION:** Members with a 4T profile incurred in the line of duty will be retained on military orders until the profile is resolved or the member is processed through the DES. Only HQ AFRC/SG may remove a 4 profile assigned because a member currently has or has a history of a disqualifying medical condition. For ANG members, the State Air Surgeon may grant an interim waiver for IDT only in the likelihood the member will be returned to duty.

4.6.3. Profile after MEB/PEB action: All active duty members returned to duty by MEB/PEB and those given an assignment limitation code-C (ALC-C) by AFPC/DPAMM will be profiled by the local profiling officer. All individuals with an ALC-C must be on a 4T profile. Document the ALC-C restriction in the remarks section of the AF Form 422 for easy identification by the MPF when updating the PDS system or when considering medical retraining (if warranted). When required for medical retraining, document in the remarks section the final revised profile (PULHES) of the medical condition(s) along with any restrictions, even though the member is on a 4T due to the ALC-C action. This new revised PULHES listing in the remarks section will allow the MPF personnel the ability to determine which career fields the member can be considered for, if medical retraining is warranted. Additionally, the profile should indicate when the next in-lieu-MEB review is due at HQ AFPC/DPAMM (if required).

(Example: For purposes of retraining, only the member's profile is revised to "xxxxxx" and at the minimum all must be 3s. The appropriate career field functional manager (CFM) must concur that the member can be utilized in the requested career field.

***NOTE:*** If a member is returned to unrestricted worldwide service by MEB/PEB (without ALC-C action), do not assume that the member's condition is compatible with mobility, deployment or overseas assignments. Any limitations placed on the member as a result of "this condition" should be listed on an AF Form 422. Under "comments" state that the member has undergone an MEB for this condition and was returned to duty. Members on a 4T Profile for more than one year do not require another MEB if there is not a change in the medical condition. If TDY or PCS is pending, address the member's qualification for mobility and deployment as a separate issue, see AFI48-123V4, Attachment 5, and coordinate questionable conditions with the gaining MAJCOM/SG if PCS is pending. Profiles for members returned to duty following MEB/PEB with ALC-C require annual review.

4.6.4. Active Guard Reserve (AGR) members are placed on ALC-C or Deployment Availability Code-42 by the appropriate ARC/SG and will be appropriately profiled and reevaluated IAW guidance from the appropriate AGR Surgeon.

**4.7. Duty Limitations.**

4.7.1. Temporary Assignment and Deployability Limitation:

4.7.1.1. A 4T profile precludes reassignment until the MEB or PEB processing is completed or the condition is resolved.

4.7.1.1.1. A 4T profile is by definition not permanent and may not be imposed for more than 12 months without MEB/PEB action. Medical conditions requiring a profile are cumulative in nature. Even when profile periods are intermittent, the sum from date related condition onset of symptoms or diagnosis (whichever is oldest) is totaled to determine the cumulative days.

4.7.1.1.2. A 4T profile precludes deployment. If the commander believes the benefit to the mission outweighs the potential risk to the member, he/she may consult with MDG/SGP prior to deploying the member. An info copy of any such actions will be electronically sent to the MAJCOM/SGPA. High risk cases (ALC-C or in SGP's opinion), where there is an obvious and high degree of threat to a member's personal safety or health will require HQ AFPC/DPAMM consultation and approval.

4.7.1.1.3. A "T" suffix precludes overseas PCS assignment until the condition is resolved, or member is returned to duty following MEB/PEB.

4.7.1.1.4. When an assignment is pending (confirmed by MPF), the health care provider provides the medical facts and circumstances to the physician at HQ AFPC/DPAMM, Randolph AFB TX via narrative summary, or telephone, or with a properly filled out AF Form 422.

***NOTE:*** Disclosure of PHI should be IAW 1996 Health Insurance Portability and Accountability Act (HIPAA) and AFI 41-210.

4.7.2. Temporary Occupational Restriction. Use AF Form 422 or AF Form 1042 (for flying or special operational personnel) to inform the member's unit commander or supervisor that member has an injury or illness which limits job performance, or deployability, for a specified duration. Submit to the MPF those 4T profiles issued for injuries or illnesses not compatible with worldwide assignment or mobility (deployability) and are not expected to resolve within 60 calendar days. Pregnancy profiles must be completed within 5 work days of the receipt of a positive pregnancy test. Pregnancy profiles expire six weeks post-EDC (adjustments must be made for actual date of delivery). This standard can be made more stringent at the discretion of the local occupational working group but not less stringent. 4T profiles issued for periods of 60 days or less are not forwarded to the MPF. However, they still must be used to communicate with the unit commander. For ARC members, forward a copy of all "4" profiles to the member's supporting ARC MPF and immediate commander regardless of expected date of resolution. In all cases where standards for continued military service, deployment or mobility are not met, the AF Form 422 shall be annotated "not qualified for mobility or deployment" and the worldwide assignment block shall be checked "no." As noted in AFI48-123V4 Attachment 5, it is entirely possible for one to be qualified for worldwide service IAW **Attachment 2**, yet be not qualified for deployment or mobility. Care must be used in making sure this is communicated to Unit Deployment Managers (UDMs) or Installation Deployment Officers (IDOs) as applicable.

4.7.3. Permanent Assignment or Deployment Restriction. ALC-C justifies use of the 4T profile and precludes deployment and unrestricted assignment until removed.

***NOTE:*** For Reserve members a 3C profile will be used instead of the 4T profile to identify ALC-C status, once approved by the ARC/SG. No Reserve member assigned an ALC-C may perform military duty OCONUS unless approval is specifically granted by AFRC/SG. ANG members are placed on P4 profile if assigned an ALC-C/DAC-42 and may deploy only to non-remote locations in CONUS, Hawaii, Puerto Rico and Alaska and United States territories while in this status as long as restrictions annotated in the remarks section of the AF Form 422 are not violated.

4.7.4. For active duty members the ALC-C does not necessarily preclude retraining.

**4.8. Additional Uses of AF Form 422.**

4.8.1. Notification to the MPF of the member's qualification for continued service on the occasion of retirement or separation.

4.8.2. Drug Abuse Reporting to commanders, social actions officers, and other responsible parties of active duty personnel identified as drug experimenters, users, or addicts.

4.8.3. AFSC Medical Retraining:

4.8.3.1. When a medical defect permanently precludes further employment within a member's AFSC, a medical recommendation for retraining is sent to the servicing MPF on an AF Form 422 according to AFI 36-2101, *Classifying Military Personnel (Officers and Enlisted)* paragraph 4.1.7. A Narrative Summary (SF Form 502, *Medical Record – Narrative Summary Clinical Resume*)

must accompany the AF Form 422. The narrative summary should include comments clearly defining the individual's limitations, a recommendation by the member's squadron commander, and approval by the MTF commander or senior profile officer. The last page of the narrative summary should include an endorsement (approve/disapprove) by the member's squadron commander and an endorsement (approve/disapprove) by the MTF commander or senior profile officer.

4.8.3.2. The MPF determines the retraining AFSC and notifies Public Health or the ARC medical unit. The member's PCM team and Public Health or the ARC medical unit must certify the member medically qualified, or not qualified, for each selected or requested AFSC. Medical waivers will not be granted to allow a member to cross train into another AFSC when defect is disqualifying for both AFSCs.

4.8.3.2.1. Consult the Career Field Manager through the MAJCOM AFSC Functional Manager to determine if retraining into a certain AFSC is appropriate with medical defects causing the medical retraining action.

4.8.3.2.2. Very few AFSCs require mobility qualification for award or retention of an AFSC. Review AFMAN 36-2108, *Enlisted Classification*, for medical qualification in prospective AFSC for which the member is applying. Approval authority for retraining is the personnel system.

4.8.3.3. Recommendations are disapproved and MEB is indicated when the defect:

4.8.3.3.1. Is permanent and precludes worldwide assignment

4.8.3.3.2. Existed prior to service (EPTS).

4.8.3.3.3. Precludes cross training to alternate AFSC occupations commensurate with the member's grade and office.

4.8.3.3.4. For members who have had MEB processing and returned to duty see paragraph **4.6.3.**

4.8.4. Validating the member's profile for placement into the Personnel Reliability Program.

4.8.4.1. See AFI 36-2104, *Nuclear Weapons Personnel Reliability Program* for detailed information concerning PRP and profiling.

4.8.5. Notification to unit commander of member's refusal to submit DNA sample or other required medical force protection or readiness measures. The AF Form 422 may be used to notify the unit commander when such samples or tests are not on file, or when a member refuses to provide required items.

4.8.6. Physical Restrictions/Fitness Exemptions (see paragraph **4.5.5.** and AFI 10-248 for additional instruction). AF Form 422 will be utilized to communicate the fitness condition of members to the unit commander. Utilize the fitness section to communicate fitness status. The following situations will require an AF Form 422:

4.8.6.1. When a member who has a chronic and stable condition which imposes physical restrictions but does not preclude worldwide duty assignment, deployability, mobility, or participation in either fitness training or fitness testing. An AF Form 422 can be processed without an expiration date, as a permanent profile of 1, 2, or 3 (see AFPAM 48-133 for further guidance).

4.8.6.2. Complete excusal from fitness training or testing due to a temporary medical condition. The appropriate section of the AF Form 422 needs to reflect the expected duration of the profile and list alternative options for fitness training. If that duration is expected to last less than 60 days, then process the profile in accordance with applicable directives. If expected to last greater than 60 days but less than 1 year, MEB action is not required. If the condition is permanent or expected to last more than 1 year, or if the member has been on a profile for more than 1 year, an MEB must be considered as noted in **4.5.5.2.3.** to determine qualification for continued military service.

4.8.6.3. Members identified as a high cardiovascular risk for the 1.5-mile run during their annual PHA. These individuals will need to be evaluated by their provider to determine if their risk can be mitigated with treatment or lifestyle changes. The provider will need to determine if the member can participate in unit training, if they should perform the 1.5 mile run or a sub maximal test for their aerobic fitness assessment (see AFI 10-248).

4.8.7. Members undergoing alcohol rehabilitation. (Those diagnosed with DSM IV criteria for alcohol abuse or dependence), in the Alcohol & Drug Abuse Prevention & Treatment (ADAPT) program will require a 4T in order to allow completion of treatment. The 4T profile will not extend beyond 18 months. This should allow sufficient time for program completion and will not require Medical Evaluation Board (MEB) unless there is secondary disease process requiring MEB per **Attachment 2.**

4.8.7.1. Members in ADAPT will not be removed from 4T profiles early for the purpose of obtaining assignment or assignment eligibility. Consultation with the SGP and the Chief, Life Skills will determine appropriate action. The goal is to ensure persons are not placed at increased risk of relapse or treatment failure due to unusually stressful changes (e.g. deployment).

**4.9. Use of the Department of the Army (DA) Form 3349.** DA Form 3349, *Physical Profile Serial,* is acceptable in lieu of AF Form 422. Review any entry in DA Form 3349 that recommends temporary or permanent geographic or climate assignment restrictions. An Army "3" profile is not compatible with worldwide assignment in the Air Force and must be converted to a "4" profile. Profile accomplished on these forms must be reviewed and co-signed by a provider member of Primary Care Element (PCE).

**4.10. Medical Evaluation Board (MEB) General Information.**

4.10.1. Guidance for processing MEBs is contained in AFI 41-210, *Patient Administration Functions,* Chapter 10.

4.10.2. AFRC Surgeon. Reviews all MEBs on AFRC members eligible for disability processing prior to forwarding to HQ AFPC. Determines medical qualification for continued military duty on AFRC members with questionable or disqualifying medical conditions who are not eligible for disability processing. Assigns ALC-C to Reserve members (see paragraph **7.1.3.**).

4.10.3. HQ AFPC/DPPDS (see **4.4.8.**).

4.10.4. MTF Profile Officers. When notified of MEB/PEB decision completes appropriate profile action to include permanent changes if required. The PCM with approval of an appointed profile officer is responsible for proper profiling and restrictions. If the member is processed through the MEB/PEB system, and returned to full duty, without ALC-C, the member may not be suitable for deployment due to restrictions imposed by the profile officer, see AFI 48-123V4, Attachment 5.

4.10.5. Temporary Disability Retirement List (TDRL) Process. The AFI 36-3212, *Physical Evaluation For Retention, Retirement, and Separation*, Section 7.10, Processing at the Examining Facility,

states that the commander of the examining facility or designated representative makes sure the medical facility completes the examination as quickly as possible so the member may return to his or her home without delay. The commander may utilize his/her resources and personnel to best meet a quality and expeditious TDRL process. The commander should consider utilizing the PEBLO clerk to ensure the administrative duty of scheduling TDRL appointments is properly conducted, however, this action is at the discretion of the commander.

4.10.6. Statement attesting to member having met MEB and was returned to duty post MEB be carried forward on all successive profiles (including statements for those who have an ALC-C).

***NOTE:*** Members noted with overseas assignments who have potentially disqualifying conditions or medical conditions that may warrant specialty follow-up overseas are coordinated with HQ AFPC/DPAMM.

## Chapter 5

## EXAMINATION AND CERTIFICATION OF AIR RESERVE COMPONENT MEMBERS (ARC) NOT ON EXTENDED ACTIVE DUTY (EAD)

**5.1. Purpose.** This chapter implements DoD Directive 1205.9, 6 October 1960, as required by 10 U.S.C. 12644. Establishes procedures for accomplishing, reviewing, certifying, and administratively processing medical examinations for ARC members not on EAD who are assigned to the Ready Reserve and Standby Reserve. IAW AFMAN 36-8001, *Reserve Personnel Participation and Training Procedures*, any USAFR member profiled "4" may not perform military duty for pay or points. Any condition in the opinion of the provider of care is felt to be unacceptable for continued military service is reason for performing an MEB for active duty or worldwide duty medical evaluation for ARC members. Questionable conditions should be addressed to the senior profile officer, and if required, to HQ AFPC/DPAMM for active duty members and to the appropriate ARC/SG for ARC members.

**5.2. Terms Explained:**

5.2.1. Air Reserve Component (ARC). Unit and individual members of the Air National Guard (ANG) and Air Force Reserve (AFRC, IMA).

5.2.2. ARC Members of the Ready Reserve:

5.2.2.1. Air National Guard. Administered by ANG/SGP.

5.2.2.2. Air Force Reserve Unit Member. Administered by HQ AFRC/SGP.

5.2.2.3. Individual Mobilization Augmentee (IMA). Administered by HQ AFRC/SGP.

5.2.2.4. Participating Individual Ready Reserve Members (Category E). Administered by HQ AFRC/SGP.

5.2.3. Nonparticipating Members of the Ready, Standby, and Retired Reserve. These members are ordered to EAD only in time of war or national emergency declared by the Congress.

**5.3. Medical Standards Policy.** Each ARC individual must be medically qualified for deployment and worldwide duty according to **Attachment 2** and AFI 48-123V4 Attachment 5.

**5.4. Specific Responsibilities:**

5.4.1. Commander or Supervisor. Each ARC commander or active force supervisor ensures an ARC member is medically qualified for worldwide duty. Each commander and supervisor notifies the servicing medical facility when he/she becomes aware of any changes in an ARC member's medical status.

5.4.2. ARC Member. Each ARC member is responsible for promptly reporting a disease, injury, operative procedure or hospitalization not previously reported to his or her commander, supervisor, or supporting medical facility personnel. Any concealment or claim of disability made with the intent to defraud the government results in legal action and possible discharge from the ARC.

5.4.3. ARC Physicians. Responsible for determining ARC member's medical qualifications for continued worldwide duty IAW this instruction and appropriate ARC supplemental guidance.

5.4.4. Air Force medical service personnel record any injury or disease incurred or contracted by ARC members during any training period on appropriate medical forms since the injury or disease is the basis for a claim against the government, to include initiation of a Line of Duty Determination.

**5.5. General Responsibilities/ARC Medical Units:**

5.5.1. Establish health and dental records for each ARC member.

5.5.2. Forward original IMA medical examinations to the AD MTF where the individual's medical records are maintained. Examination with disqualifying medical conditions will be forwarded to HQ AFRC/SGP for appropriate disposition.

5.5.3. Medical examinations accomplished on unit assigned and IMA members of the AFR are subject to review by AFRC/SGP to verify their medical qualification for continued military duty. AFRC/SGP is the final authority in determining medical qualifications for all reserve personnel.

5.5.4. All Air National Guard medical examinations are maintained by the servicing medical unit and are subject to review by ANG/SGP to verify qualification for participation. ANG/SGPA is the final authority in determining Air National Guard member qualification for worldwide duty.

5.5.5. Send complete medical case files on ARC members with questionable medical conditions or found medically disqualified. For Air National Guard members, send medical case files to: ANG/SGPA, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157; for Air Force Reserve members (unit assigned and IMA), send to: HQ AFRC/SGPA, 135 Page Road, Robins AFB, GA 31098-1601.

**5.6. Inactive/Retired Reserve.** Applicants currently assigned to the inactive or Retired Reserve or retired from active military service for less than 5 years may request entry to active reserve status.

5.6.1. The appropriate ARC/SG must review and certify all applicants identified with **Attachment 2** disqualifying medical conditions; history of MEB evaluation, fitness for duty evaluation, or ALC-C status; applying for a different aircrew AFSC from their previous aircrew assignment, require a medical waiver for flying, or retired from a sister service.

5.6.2. The Chief, Aerospace Medicine of the gaining/supporting AFRC medical unit or active duty MTF and ANG State Air Surgeon may certify, but not waiver for entry into active reserve status all applicants not identified in paragraph **5.6.1.** above using **Attachment 2** medical standards.

5.6.3. The following documentation is required for all applicants:

5.6.3.1. Current DD Form 2807-1 (Recruiting Form).

5.6.3.2. Current Reserve Component Health Risk Assessment (RCHRA) with supporting documentation for positive responses (AFRC only).

5.6.3.3. RCPHA/PHA with associated paperwork less than 12 months old (non aircrew assignments).

5.6.3.4. Flying RCPHA/PHA with associated paperwork less than 12 months old (aircrew assignment same as previous aircrew AFSC).

5.6.4. Applicants applying for a new aircrew position, rather than the one previously held will require an initial flying exam. Applicants whose RCHRA or RCPHA/PHA is greater than 12 months old will require a current enlistment or flying exam as appropriate.

**5.7. Reenlistment.** Ensure members who want to reenlist in the ANG have a current RCPHA within the past 12 months. Ensure members who want to reenlist in AFRC complete a current RCHRA unless an RCPHA or RCHRA less than 12 months is on file.

**5.8. Pay or Points.** Annually, prepare the appropriate form for Reinforcement Designees not participating for pay or points. Members who feel their medical qualification is in question attach medical documentation to the appropriate form and return the entire package to HQ ARPC/DSFS, Denver, CO 80280-5000.

**5.9. General Officers.** ANG medical units will maintain the annual RCPHA accomplished on general officers and ANG wing commanders in the medical records. Reserve medical units will forward to HQ AFRC/SGPS, a copy of all physical examinations accomplished on reserve wing commanders.

**5.10. Active Guard Reserve (AGR) Tours.** The AGR program requires individual applicants to contact the appropriate ARC medical unit, or active duty MTF, to request the appropriate medical evaluation. The following guidance along with AFI 36-2132, *Full-time Support (FTS) Active Guard Reserve* (AGR) *Program and* ANGI 36-101*, The Active Guard/Reserve (AGR) Program*, will be used to manage these requests.

5.10.1. General. Members selected for initial AGR positions must meet the medical standards as outlined in this AFI prior to assignment. Applicants who have started an AGR tour and are found to have medical conditions(s) which makes their medical qualifications for continued military duty questionable will be processed through the Air Force Disability Evaluation System (AFDES) IAW AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation.*

5.10.2. Physical Exam Requirements.

5.10.2.1. Applicants with a concurrent AGR assignment must have a current PHA on file.

5.10.2.2. Applicants with no service affiliation (i.e. Individual Ready Reserve (IRR), AD, reserve, guard, etc.) require an accession physical exam, which would be valid for 24 months prior to AGR assignment. See medical standards in **Attachment 3** and AFI 48-123V3 Attachment 4 (aircrew applicants only).

5.10.2.3. Active military (AD, ARC) applicants for non-aircrew assignments many use RCPHA/PHA with associated documentation leas than 12 months old. Members must also be current in all Individual Medical Readiness (IMR) requirements. AF Form 422, Physical Profile Serial Report, must be dated within 60 days prior to tour start date. Medical standards in **Attachment 2** apply. Prior service (IRR, etc.) applicants for non-aircrew assignments within 180 days of separation may use the same standards as active duty. Applicants whose date of separation is greater than 180 days will require an accession examination and medical standards in **Attachment 3** apply.

5.10.2.4. For aircrew assignments into the applicant's current aircrew AFSC, flying RCPHA/PHA with associated paperwork less than 12 months old may be used.

5.10.2.4.1. Applicants for new aircrew assignments require an initial flying examination.

5.10.3. Certification/Waiver Authority.

5.10.3.1. The Chief, Aerospace Medicine of the gaining/supporting ARC medical unit or active duty MTF may certify, but not waiver, all applicants for non aircrew AGR positions and aircrew

AGR positions in which the applicant currently holds the AFSC as long as no disqualifying medical conditions or medical conditions which require a flying waiver are identified. Medical standards in **Attachment 2** and AFI 48-123V3 Attachment 4 apply. For ANG, the State Air Surgeon, having completed specialized training, is authorized certification authority for Title 32 AGR applicants.

5.10.3.1.1. The Chief, Aerospace Medicine will certify the appropriate medical document with a locally developed certification stamp following the example below. Under the stamp will be the signature block and signature of the Chief, Aerospace Medicine. Delegation of this certification authority is extended only to those Reserve Medical Units responsible for providing physical exam support.

**Example:**

444 Aerospace Medicine Squadron, Jelly AFB, KY

(Certification Date)

Medically qualified for AGR position (enter AFSC)

Physician signature block and signature

5.10.3.2. The appropriate ARC/SG is the reviewing, certification and waiver authority (see AFI 48-123V4, Table A2.1.) for those applicants with disqualifying medical conditions in **Attachment 2 and Attachment 3 and** AFI 48-123V3 Attachment 4, and initial entry into all aircrew AFSC's, unless otherwise directed by other guidance within this instruction. Also, the appropriate ARC/SG is the certification authority for all MAJCOM or higher-level AGR positions (ANG Title 10 EAD) and those positions with no gaining ARC medical units.

**5.11. Involuntary EAD:** ARC members involuntarily ordered to active duty will not delay such action because of an expired RCPHA. The RCPHA will be accomplished prior to deployment or TDY from the recall to active duty location. The RCPHA must be accomplished within the first 60 days of active duty.

5.11.1. An ARC member ordered to EAD due to mobilization is medially processed IAW the mobilization order. The ARC member's medical status must be established within 30 days of mobilization.

5.11.2. Within 30 days of mobilization, the health records of the ARC member will be reviewed for disqualifying defects according to **Attachment 2** and to determine if the member's RCPHA is current. Members found medically disqualified or questionably qualified for worldwide duty are evaluated IAW AFI 41-210, *Patient Administration Functions,* unless otherwise directed by the mobilization order. Members determined to have expired RCPHA, will have a PHA accomplished within 60 days of mobilization.

**5.12. Annual Training (AT) or Active Duty for Training (ADT) or Inactive Duty for Training (IDT).** Commanders ensure members reporting for duty are medically qualified under current directives. Members with medical conditions, which render questionable their medical qualifications for continued worldwide duty, are evaluated for fitness for duty.

**5.13. Inactive Duty for Training:**

5.13.1. ARC members who are ill, sustain an injury, or do not consider themselves medically qualified for military duty can request excusal from training.

5.13.2. If a member reports for duty and does not consider him or herself medically qualified, the ARC commander or active duty supervisor will schedule the member for a medical evaluation during the IDT period. If the member is not qualified for worldwide duty, a medical evaluation is sent to HQ AFRC/SGP, or ANG/SGPA as appropriate. The member is excused from training pending a review of the case. For ANG members, the State Air Surgeon may grant an interim waiver for IDT in the likelihood the member is returned to duty.

5.13.3. When a commander, supervisor, or medical personnel determines an ARC member's medical condition is unfit, he or she is evaluated by the servicing medical squadron and is excused from all military duties pending further medical disposition.

**5.14. Medical Examination:**

5.14.1. General Information:

5.14.1.1. Medical personnel perform medical examinations according to AFI 48-123V1 Chapter 1 and AFPAM 48-133.

5.14.1.2. All personnel undergo an annual dental examination according to the PHA grid at the time of the RCPHA. Bitewing radiographs are accomplished at the discretion of the examining dental officer for diagnostic assistance.

5.14.1.3. All Air National Guard members must complete their RCPHA annually.

5.14.1.4. ANG Military Personnel Flight (MPF) and commander are notified by the ANG Medical Group when a member cannot continue the UTA because of a medical condition. AF Form 422 is utilized for notification, as appropriate.

5.14.2. Dental Class III.

5.14.2.1. ARC members placed in dental class III are not medically qualified for continued military duty. Manage AFRC members IAW paragraph **5.16.** of this instruction unless the dental officer has determined the member may continue reserve participation in restricted status.

5.14.2.2. The examining military dental officer has the authority to allow reservists in dental class III to continue Reserve participation at home duty station only while undergoing corrective dental treatment. The dental officer will determine the length of time (not to exceed 1 year) given to a member to complete dental treatment or improve to at least dental class II.

5.14.2.2.1. Aircrew members in dental class III will be placed on duties not involving flying (DNIF) status unless the examining dental officer determines the member may continue reserve participation and the flight surgeon determines flying safety will not be compromised. Aircrew in this status will be limited to local sorties only.

5.14.2.3. ANG members placed in Dental Class III are immediately placed on physical profile P4T. The State Air Surgeon may grant an interim waiver for IDT only. Aircrew members in dental class III will be placed on DNIF, and an AF Form 1042, *Medical Recommendations for Flying or Special Operational Duty*, will be accomplished and Aircrew members may not perform flying

duty while in Dental Class III. For additional guidance, see AFI 47-101, *Managing Air Force Dental Service*s.

**5.15. Scheduling RCPHA.** Schedule a RCPHA in accordance with current ARC directives (RCPHA Implementation Guide).

**5.16. Medical Evaluations to Determine Fitness for Duty.**

5.16.1. Reasons to accomplish medical evaluations in determination of medical and dental qualification for military duty:

5.16.1.1. Disqualifying or questionable medical conditions discovered during the annual assessment.

5.16.1.2. Notification or awareness of a change in the member's medical status.

5.16.1.3. ARC member believes he or she is medically disqualified for military duty.

5.16.2. Reservists and ANG members with medical or dental conditions which are questionable or disqualifying for military duty must have an evaluation accomplished and forwarded to the appropriate ARC/SG for review and appropriate action. Members will be given a minimum of 60 days from the date of notification to provide civilian medical or dental information to the medical squadron prior to case submission to the ARC/SG. The local military provider may give the member more time as considered necessary to provide the requested information. However, under no circumstances will the time exceed 1 year.

5.16.3. Notification. The commander or supervisor notifies the ARC member, in writing, to report for the medical evaluation.

5.16.4. Accompanying Documents. The following documents are included in the reports forwarded to the appropriate component surgeon (see paragraph **5.5.**) for review. Unless otherwise specified all reports contain the original and two copies of each document, properly collated and stapled into three separate stacks.

5.16.4.1. For unit assigned or IMA reserve members:

5.16.4.1.1. Civilian medical and dental documentation.

5.16.4.1.2. Current letter from member's private physician or dentist.

5.16.4.1.3. AF Form 422 properly formatted.

5.16.4.1.4. SF 502, *Medical Record - Narrative Summary Clnical Resume*, must provide a clear picture of the member's current medical health as well as the circumstances leading to it.

5.16.4.1.5. Medical Evaluation (ME) for Military Duty Fact Sheet.

5.16.4.1.6. Commander utilization questionnaire.

5.16.4.1.7. Physical Evaluation Board (PEB) Election.

5.16.4.1.8. Physical Evaluation Board (PEB) Fact Sheet.

5.16.4.1.9. AF Form 422, Serial Profile Report (Member Copy).

5.16.4.1.10. Unit Commander Memorandum.

5.16.4.1.11. Member Utilization Questionnaire.

5.16.4.2. For ANG members:

5.16.4.2.1. Unit commander's endorsement.

5.16.4.2.2. SF 502, Narrative Summary should include:

5.16.4.2.2.1. Date and circumstance of occurrence.

5.16.4.2.2.2. Response to treatment.

5.16.4.2.2.3. Current clinical status.

5.16.4.2.2.4. Proposed treatment.

5.16.4.2.2.5. Current medications.

5.16.4.2.2.6. The extent to which the condition interferes with performance of military duty (see AFI 48-123V4 Attachment 5).

5.16.4.2.2.7. Prognosis.

5.16.4.2.3. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ANG members. The provider will review this information and reference it in the SF 502, Narrative Summary.

5.16.4.2.4. A written statement from the member's immediate commanding officer describing the impact of the member's medical condition on normal duties and ability to deploy or mobilize.

5.16.5. Reports. A member who is unable to travel submits a report from his or her attending physician to their commander or supervisor who, in turn, submits the report to the servicing ARC medical squadron for review and determination of fitness for duty.

**5.17. Failure to Complete Medical Requirements.** ARC and ANG members who fail to complete medical/dental requirements are referred to their commanders IAW AFMAN 36-8001, and are processed IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Member*s.

***NOTE:*** ANG members who fail to complete any requirements (i.e., PHA, dental, immunizations, etc.) are placed on P4T status.

5.17.1. Refusal. An ANG member with a known medical or dental condition who refuses to comply with a request for medical information or evaluation is considered medically unfit for continued military duty and is referred to their immediate commander for processing IAW AFI 36-3209, *Separation and Retirement Procedures For Air National Guard and Air Force Reserve Members.*

## Chapter 6

## MEDICAL EXAMINATION, ASSESSMENT, MISCELLANEOUS ACCOMPLISHMENT AND RECORDING

**6.1. General Information.** The health record is a medical and legal document. Accuracy and completeness in all entries is essential.

**6.2. Medical History.** If the patient's health record contains a completed SF Form 93, or DD Form 2807-1, and the individual acknowledges that the information is current and correct, do not accomplish a new form.

6.2.1. Changes. Make an addendum to the most current or complete Report of Medical History by adding any significant items of interval history since the last Report of Medical History was accomplished.

6.2.2. Additional Space. Use SF Form 507, *Medical Record-Report on ____ or Continuation of SF ____*, as an attachment to the Report of Medical History when additional space is required. (See AFPAM 48-133).

6.2.3. Report of Medical History. SF Form 93 (or DD Form 2807-1) is to be updated and attached to SF 88/DD Form 2808, or the Preventive Health Assessment (PHA), where required, when medical examinations are accomplished for the following purposes:

6.2.3.1. Entry into active military service.

6.2.3.2. Appointment or enlistment in the Air Force or its Reserve Forces.

6.2.3.3. Retirement or separation from active military service as specified by this instruction.

6.2.3.4. Periodic flying and non-flying assessments as specified in AFI 48-123V3 Attachment 4.

6.2.3.5. Whenever an examination is sent for higher authority review.

6.2.3.6. Whenever considered necessary by the examining health care provider; for example, after a significant illness or injury or commander directed physical assessment.

6.2.3.7. Examination of an ARC member. For ANG flying and non-flying health assessments, accomplish a PIMR-generated SF 507 in place of updated SF 93/DD Form 2807-1.

6.2.3.8. Lost medical records. Accomplish a PHA with Report of Medical History.

***NOTE:*** Accomplish electronically when original history was done electronically.

**6.3. Interval Medical History.** Once a complete medical history has been recorded on a SF Form 93 or DD Form 2807-1, only significant items of medical history since the last medical examination are recorded. This is called the interval medical history.

6.3.1. Changes in Flight Status. Any significant medical condition requiring hospitalization, excusal, grounding, profile change or suspension from flying status is recorded as part of the interval medical history. The information concerning the interval medical history is obtained by questioning the examinee and by a thorough review of the examinee's health records.

6.3.2. Updates. The interval medical history is recorded on SF Form 93, item 25 or continued on SF 507 and on DD 2807-1, item 30. Reference each update to the medical history with the current date, followed by any significant items of medical history since last examination. Most recent SF 93 or DD Form 2807-1 and all subsequent SF 507 must be filed together chronologically as all of these forms comprise the medical history. ANG will only use PIMR generated SF 507 for interval history.

6.3.3. Significant Medical History. Use SF Form 93/DD Form 2807-1, waiver requests, MEB diagnosis, or restricted duty for 30 days or more as a guide in determining items to include as significant medical history. Do not record "routine" items such as URIs, viral illnesses, etc., unless hospitalization was required or the illness is of a frequent or chronic nature.

6.3.4. Denial Statement. After recording the interval medical history, the following denial statement is recorded: "No other significant medical or surgical history to report since last examination (enter the date of that examination in parentheses)."

6.3.5. No Interval Medical History Statement. If the examinee had no interval medical history, record the current date followed by the statement: "Examinee denies and review of outpatient medical record fails to reveal any significant interval medical or surgical history to report since last examination dated (enter the date of that examination in parentheses)." See AFPAM 48-133 for denial statement used when accomplishing the initial SF Form 93 or DD Form 2807-1.

**6.4. Medical Examinations.** The results of medical examinations are recorded on SF 88/DD Form 2808 or approved substitutes in accordance with AFPAM 48-133.

**6.5. DD Form 2697.** DoD directs that DD Form 2697 be accomplished for all members separating or retiring from active duty, consult **Chapter 1**.

**6.6. Adaptability Rating for Military Aviation (ARMA) and other military duties** , such as for Air Traffic Control Duty (AR-ATC), Space and Missile Operations Duty (AR-SMOD), etc., is the responsibility of the examining flight surgeon, as is the scope and extent of the interview. Initial (entry into training) unsatisfactory adaptability ratings are usually rendered for poor motivation for flying (or other duty), or evidence of a potential safety of flight risk, etc. (see AFI 48-123V3 Attachment 4.25. and AFPAM 48-133, *Physical Examination Techniques* for further information.

**6.7. DD Form 2766.** DD Form 2766 is used to record results of tests such as blood type, G6PD, DNA, GO, NO-GO pills, etc., and also used as a deployment document as the AF Form 1480A, IAW AFI 10-403, *Deployment, Planning and Execution*, paragraph 1.5.18.2. which requires the medical group commander to provide a current DD Form 2766 for all deploying personnel.

## Chapter 7

## OCCUPATIONAL HEALTH EXAMINATIONS

**7.1. Purpose.** Occupational health examinations are done to ensure fitness for duty, to protect the working population by assessing adequacy of controls, and to identify work-related illness at a sub clinical state where a useful intervention can be made. The examinations are conducted to assist in maintaining a fit force essential to mission readiness and to assure the Air Force meets its obligation under the Occupational Safety and Health Act of 1970 (29 USC 651) to provide a safe and healthful workplace. Instruction and guidance for occupational health examinations can be found in AFI 48-145, *Occupational Health Program*, AFOSH STD 48-20, Hearing Conservation Program, AFOSH STD 48-137, *Respiratory Protection Program,* AFOSH STD 48-8, *Controlling Exposures to Hazardous Materials* and DoD 6055.5-M, *Occupational Health Surveillance Manual*.

**7.2. Who Receives These Examinations.**

7.2.1. The local Occupational Health Working Group (OHWG) determines the need, type and frequency of exams for both civilian and military workers.

**7.3. Public Health (SGP for the ARC).** Performs administrative quality control review/oversight on these examinations to ensure completeness. Where examinations are completed along with PHA MTF/CC may combine PHA and OH reviews to be accomplished concurrently by one section.

**7.4. Results of Occupational Health Examinations.** Results of occupational health examinations are maintained in accordance with AFOSH standards and AFI 48-145 and are one source of input to the multidisciplinary Occupational Health Program.

**7.5. Types of Examinations.**

7.5.1. Detailed guidance for clinical surveillance examinations are found in AFI 48-145 and DoD 6055.5-M.

**7.6.** Examination Requirements.

7.6.1. Examination requirements are determined by the installation OHWG. Details on the OHWG process are found in AFI 48-145.

7.6.2. Useful guidance for examination criteria is found in DoD 6055.5-M, *Occupational Health Surveillance Manual* AFI 48-145, *Occupational Health Program,* AFOSH STD 48-137, AFOSH STD 48-8, *Controlling Exposures to Hazardous Materials* and NEHC-TM OM 6260, Medical Surveillance Procedures Manual and Medical Matrix.

**7.7. Forms Required.**

7.7.1. Standard Form 78, *Certificate of Medical Examination*s: This form is used when the management or the civilian personnel office formally requests an examination under 5 Code of Federal Regulations (CFR), 339, *Medical Qualification Determinations.* This form provides a listing of functional and environmental factors essential to the examination and placement of civilian workers.

7.7.1.1. Management should provide the SF 78 and a listing of functional and environmental factors essential to the examination and placement of the civilian worker. The medical provider records findings and conclusions on the SF 78 and returns page 3 of this form to the responsible personnel office. Utilization of DD Form 2766 for additional pre-employment examination criteria will provide for one-stop examination and established baseline occupational studies.

7.7.1.2. A copy of the entire form SF 78 must be kept in the worker's medical record. An appropriate medical history should be obtained and documented as well (e.g. paragraph **7.7.2.**).

7.7.1.3. When completing SF 78 Section D "Agency Medical Officer", the examining provider should not make hire/don't hire/separate/retain determinations. Provider should simply describe absence or presence of functional limitations and/or unacceptable environmental factors. If a provider feels a condition is disqualifying based on a particular medical standard, consultation (at least telephonic) with a Board Certified occupational medicine physician should be obtained.

7.7.2. Standard Form 600, *Health Record—Chronological Record of Medical Care*. This form can be used for informal examinations (for example, examinations performed periodically during recovery from an injury).

7.7.3. Other forms. The Air Force Form 422, *Physical Profile Serial Report* can also be used for the communication of functional abilities, as well as a CA-17, CA-20 or other appropriate form.

**7.8. Consultations.** If the healthcare provider suspects an individual's illness is job-related, the practitioner notes pertinent historical and clinical data on SF Form 513, *Medical Record--Consultation Shee*t, and sends it to Public Health.

GEORGE P. TAYLOR, JR, Lt General, USAF, MC, CFS
SURGEON GENERAL

## Attachment 1

## GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

***References***

DoD Manual 6055.5, *Occupational Health Surveillance Manual*

DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*

DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*

DoD Instruction, 1342.19, *Family Care Plan*

DoD Instruction, 6130.4, *Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces*

Executive Order 9397

Occupational Safety and Health Act of 1970 (29 USC 651)

Title 10, United States Code, Section 8013

Title 10, United States Code, Section 113

Title 10, United States Code, Chapter 8502

Title 32, United States Code

Title 38, United States Code

5 Code of Federal Regulations (CFR) 339, Medical *Qualification Determinations*

AFPD 48-1, *Aerospace Medical Program*

AFI 10-248, *Fitness Program*

AFI 10-403, *Deployment Planning and Execution*

AFI 33-324, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*

AFI 36-2101, *Classifying Military Personnel (Officers and Enlisted)*

AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*

AFI 36-2110, *Assignments*

AFI 36-2626, *Airman Retraining Program*

AFI 36-3203, *Service Retirements*

AFI 36-3209, *Separation and Retirement Procedures For Air National Guard and Air Force Reserve Members*

AFI 36-3212, *Physical Evaluation for Retention, Retirement or Separation*

AFI 41-210, *Patient Administration Functions*

AFI 44-109, *Mental Health and Military Law*

AFI 44-119, *Clinical Performance and Improvement*

AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

AFI 47-101*, Managing Air Force Dental Services*

AFI 48-123 Vol 1, *Medical Examinations and Standards – General Provisions*

AFI 48-123 Vol 3, *Medical Examinations and Standards – Flying and Special Operational Duty*

AFI 48-123 Vol 4*, Medical Examinations and Standards – Special Standards and Requirements*

AFI 48-123/AFRC Supplemen*t, Air Force Reserve supplement to AFI 48-123 for unit assigned reservists*

AFI 48-135*, Human Immunodeficiency Virus Program*

AFI 48-145, *Occupational Health Program*

AFMAN 36-2105*, Officer Classification*

AFMAN 36-2108, *Enlisted Classification*

AFMAN 36-8001, *Reserve Personnel Participation And Training Procedures*

AFMAN 37-123, *Management of Records*

AFPAM 48-133, *Physical Examination Techniques*

AFRC 48-101, *Respiratory Protection Program*

AFOSH STD 48-8, *Controlling Exposures to Hazardous Materials*

AFOSH STD 48-20, *Hearing Conservation Program*

ANGI 36-101, *The Active Guard/Reserve (AGR) Program*

***Abbreviations and Acronyms***

**ADHD—**Attention Deficit Hyperactivity Disorder

**ADT—**Active Duty Tour

**AFIP—**Armed Forces Institute of Pathology

**AFI—**Air Force Instruction

**AFMOA—**Air Force Medical Operation Agency

**AFMOA/SGPA—**Air Force Medical Operation Agency, Aerospace Medicine Directorate

**AFPC—**Air Force Personnel Center

**AFRC—**Air Force Reserve Command

**AFROTC—**Air Force Reserve Officer's Training Corps

**AFSC—**Air Force Specialty Code

**AGR—**Active Guard Reserve

**ANG—**Air National Guard (Previously, Air National Guard Readiness Center)

**ANSI—**American National Standards Institute

**ARC—**Air Reserve Components (ANG, IMA and unit reservists)

**ARC SURGEON—**HQ AFRC/SGP for unit assigned and IMA members of the Air Force Reserve; ANG/SGP for guardsmen

**ARPC—**Air Reserve Personnel Center

**ATS/USPHS—**American Thoracic Society and U.S. Public Health Service

**AV—**Atrioventricular

**cm—**Centimeter

**CNS—**Central Nervous System

**CONUS—**Continental United States

**dB—**Decibel

**DNIF—**Duties Not Involving Flying

**DoD—**Department of Defense

**DoDD—**Department of Defense Directive

**DoDI—**Department of Defense Instruction

**DSM—**Diagnostic and Statistical Manual

**EAD—**Extended Active Duty

**ECG—**Electrocardiogram

**EPTS—**Existing Prior to Service

**FFD—**Fitness for Duty

**G6PD—**Glucose-6-phosphate dehydrogenase

**HIV—**Human Immunodeficiency Virus

**HIPAA—**Health Insurance Portability and Accountability Act

**HQ AFRC/SGP—**Headquarters Air Force Reserve Command, Aerospace Medicine Division

**HQ USAF/SG—**Headquarters United States Air Force Surgeon General

**ICD—**International Classification of Disease

**IDT—**Inactive Duty for Training

**IMA—**Individual Mobilization Augmentee

**IMR—**Individual Medical Readiness

**IRR—**Individual Ready Reserve

**ISO—**International Standards Organization

**LASEK—**Laser Epithelial Keratomileusis

**LASIK—**Laser-Assisted In Situ Keratomileusis

**MAJCOM—**Major Command

**MEB—**Medical Evaluation Board

**MEPS—**Military Entrance Processing Station

**MilPDS—**Military Personnel Data System

**mm—**Millimeter

**mmHg—**Millimeters of mercury

**MPF—**Military Personnel Flight

**MTF—**Medical Treatment Facility

**MUGA—**Multiple Gated Acquisition

**PCM—**Primary Care Manager

**PCS—**Permanent Change of Station

**PEB—**Physical Evaluation Board

**PEBLO—**Physical Evaluation Board Liaison Officer

**PHA—**Preventive Health Assessment

**PHI—**Protected Health Information

**PIMR—**Preventive Health Assessment And Individual Medical Readiness

**RCHRA—**Reserve Component Health Risk Assessment

**RCPHA—**Reserve Component Periodic Health Assessment

**RD—**Reinforcement designees

**RDS—**Records Disposition Schedule

**RK—**Radial Keratotomy

**ROTC—**Reserve Officer Training Corps

**RPR—**Rapid plasma reagin

**SAT—**Strength Aptitude Test

**TDRL—**Temporary Disability Retirement List

**TDY—**Temporary Duty

**USAFR—**United States Air Force Reserve. Includes unit assigned reservists and Individual Mobilization Augmentees (IMA)

**VDRL—**Venereal Disease Research Laboratory

## Attachment 2

## MEDICAL STANDARDS FOR CONTINUED MILITARY SERVICE (RETENTION)

**A2.1.** Conditions listed in this attachment require Medical Evaluation Board (MEB) processing for active duty members, worldwide duty evaluation for ARC members when appropriate (see **Chapter 5**), and are not all-inclusive. These standards and other diseases or defects not specifically listed can be cause for rejection based upon the medical judgment of the examining physician or reviewing authority.

### A2.2. Head.

A2.2.1. The loss of substance of the skull (756.0 or 738.1), with or without prosthetic replacement accompanied by residual signs or symptoms that preclude satisfactory performance of duty or unrestricted station assignability.

A2.2.2. An unprotected skull defect 3 cm in diameter or larger.

### A2.3. Mouth, Nose, Pharynx, Larynx, and Trachea.

A2.3.1. Larynx.

A2.3.1.1. Paralysis of the larynx. Characterized by bilateral vocal cord paralysis (478.3) seriously interfering with speech or adequate airway.

A2.3.1.2. Stenosis of the larynx. Of a degree causing respiratory compromise.

A2.3.1.3. Obstructive edema. Obstructive edema of the glottis, if recurrent.

A2.3.1.4. Obstructive sleep apnea requiring Continuous Positive Airway Pressure (CPAP) device.

A2.3.2. Nose, Pharynx, and Trachea.

A2.3.2.1. Rhinitis. Atrophic rhinitis, characterized by bilateral atrophy of nasal mucus membranes, with severe crusting, concomitant severe headaches, and foul, fetid odor.

A2.3.2.2. Sinusitis. Severe and chronic (473) which is suppurative, complicated by polyps, or does not respond to treatment.

A2.3.2.3. Stenosis of trachea causing respiratory embarrassment.

### A2.4. Ears and Hearing.

A2.4.1. Ears.

A2.4.1.1. Mastoidectomy. Followed by chronic infection requiring frequent or prolonged specialized medical care.

A2.4.1.2. Infections of ears or mastoids (383.9). When satisfactory performance of duty is prevented or because of the requirement for extensive and prolonged treatment.

A2.4.1.3. Meniere's syndrome (386). Recurring attacks of sufficient frequency and severity as to require frequent or prolonged medical care.

A2.4.2. Hearing (all hearing defects are coded with ICD-9 code 389).

A2.4.2.1. Hearing loss that precludes safe, effective performance of duty despite use of hearing aid. See AFI 48-123V4 Attachment 3.

**A2.5. Dental.** Diseases and abnormalities of the jaw or associated tissues which despite treatment, prevent normal mastication, normal speech or the wearing of required life support or chemical/biological warfare ensemble, or which otherwise interferes with performance.

**A2.6. Eyes and Vision.** All ophthalmological cases must include visual acuity and automated threshold perimeter charts for peripheral visual field.

A2.6.1. Any disease, injury, infection process, or sequelae involving the eye that is resistant to treatment and/or results in:

A2.6.1.1. Distant visual acuity that cannot be corrected to the standards listed at paragraph **A2.6.4.9.**

A2.6.1.2. The central field of vision in the better eye is less than 20 degrees from fixation in any direction.

A2.6.2. Aphakia (379.31), bilateral.

A2.6.3. Night blindness (368.60) of such a degree that the member requires assistance in travel at night.

A2.6.4. Even if the requirements in paragraph **A2.6.** above are met, the following manifestations of eye conditions are disqualifying:

A2.6.4.1. Glaucoma (365) with demonstrable changes in the optic disc or visual fields or not amenable to treatment.

A2.6.4.2. Retinal detachment, bilateral.

A2.6.4.3. Retinal detachment, unilateral, which results from organic progressive disease or results in uncorrectable diplopia (368.2), or visual acuity or visual field defects worse than specified above.

A2.6.4.4. Enucleated eye.

A2.6.4.5. Vision correctable only by the use of bilateral contact lenses or uncommon corrective devices, (e.g. telescopic lenses).

A2.6.4.6. Aniseikonia when incapacitating signs or symptoms exist that are not easily treatable with standard ophthalmic spectacle lenses.

A2.6.4.7. Diplopia (368.2) when symptoms are severe, constant, and in a zone less than 20 degrees from the primary position.

A2.6.4.8. Hemianopsia when bilateral, permanent, and based on an organic defect.

A2.6.4.9. Visual acuity that cannot be corrected to at least:

| Better eye | Worse eye |
|---|---|
| 20/20 | 20/400 |
| 20/30 | 20/200 |
| 20/40 | 20/100 |
| 20/50 | 20/80 |
| 20/60 | 20/60 |

A2.6.4.10. History of keratorefractive surgery, of any kind, accomplished to modify the refractive power of the cornea, or of lamellar (P11.7), penetrating keratoplasty (P11.6). Radial keratotomy (RK) is also disqualifying. RK is not compatible for continued worldwide duty; MEB is required. Corneal refractive laser surgery, including laser-assisted in situ keratomileusis (LASIK) (P11.7) laser epithelial keratomileusis (LASEK) (P11.7) or photorefractive keratectomy (PRK) (P11.7) which results in the member's inability to meet the above established vision standards or interferes with the member's ability to perform his/her duties is disqualifying.

A2.6.4.11. Keratoconus (371.6) or any other diagnoses that demonstrate by history a tendency to progress, become chronic or require long term treatment, surgical intervention or result in uncorrectable loss of vision.

**A2.7. Lungs and Chest Wall.**

A2.7.1. Active tuberculosis, where curative therapy requires 15 or more months.

A2.7.2. Symptoms of chronic or recurrent pulmonary disease, or residuals of surgery, which preclude satisfactory performance of duty. These may include:

A2.7.2.1. Significant fatigue or dyspnea on mild exertion supported by appropriate pulmonary function and blood gas studies.

A2.7.2.2. Requirement for an inordinate amount of medical observation or care over prolonged periods.

A2.7.3. Recurrent spontaneous pneumothorax when the underlying defect is not correctable by surgery.

A2.7.4. Pneumonectomy.

A2.7.5. Asthma, recurrent bronchospasm, or reactive airway disease.

**A2.8. Heart and Vascular System.**

A2.8.1. Heart disease.

A2.8.1.1. Arteriosclerotic heart disease, when associated with congestive heart failure, persistent major rhythm disturbances, repeated angina attacks, silent ischemia at a low to moderate workload or objective evidence of myocardial infarction. The following considerations pertain to myocardial infarction:

A2.8.1.1.1. Maintenance on any type of medication for the treatment or prevention of angina, congestive heart failure, or major rhythm disturbances (ventricular tachycardia, ventricular fibrillation, symptomatic paroxysmal supraventricular tachycardia, atrial flutter, or atrial fibrillation).

A2.8.1.1.2. Individuals sustaining a myocardial infarct will have MEB processing within 90 calendar days. ARC members should undergo WWD examination processing within 9-12 months following infarction.

A2.8.1.1.3. Refer to paragraph **4.11.2.** when managing cases on ARC members.

A2.8.1.1.4. Final evaluation of cases for continued active duty, and where time permits, for separation or retirement, is conducted not more than 1 year post-infarct, provided the member's clinical course is uneventful.

A2.8.1.2. Treadmill is required by medical and disability reviewing authorities in adjudication of infarction cases.

A2.8.1.2.1. Exercise Treadmill Test (ETT).

A2.8.1.2.1.1. Must achieve minimum of 85% maximum predicted heart rate for age unless heart rate is limited by medically necessary beta-blockers, in which case 3 Bruce stages (9 minutes exercise) should be attained.

A2.8.1.2.1.2. Abnormal blood pressure response.

A2.8.1.2.1.3. No reversible ischemic ST changes (i.e., no flat or down-sloping ST depressions at 80 ms past the J point; applicable only if baseline ST segments are normal; if not, imaging study is necessary).

A2.8.1.2.1.4. No significant arrhythmias.

A2.8.1.2.1.5. No symptoms or objective evidence of ischemia, angina or congestive heart failure.

A2.8.1.2.1.6. Thallium, stress echocardiogram or stress MUGA imaging if indicated by ETT (see above).

A2.8.1.2.1.6.1. No evidence of significant territories of reversible ischemia.

A2.8.1.2.1.7. Additional testing (if indicated).

A2.8.1.2.1.7.1. Baseline echocardiogram or MUGA.

A2.8.1.2.1.7.2. Evaluate left ventricular systolic function and wall motion.

A2.8.1.2.1.8. Clinical status.

A2.8.1.2.1.8.1. No angina or evidence of ischemia.

A2.8.1.2.1.8.2. No evidence of congestive heart failure.

A2.8.1.2.1.8.3. No major rhythm disturbances.

A2.8.1.2.1.8.4. No more than mild reduction in ejection fraction (i.e., greater than 45%).

***NOTE:*** MEBs on cardiac cases must include the New York Heart Association (NYHA) or Canadian Heart classification.

A2.8.1.3. Paroxysmal ventricular tachycardia, ventricular fibrillation.

A2.8.1.4. Pacemakers or implantable cardioverter-defibrillators.

A2.8.1.5. Paroxysmal supraventricular tachycardia, atrial flutter unless successfully ablated by catheter-based method (radiofrequency ablation) and not associated with structural heart disease.

A2.8.1.6. Atrial fibrillation, other than infrequent "lone" atrial fibrillation, not associated with structural heart disease and not requiring medication.

A2.8.1.7. Myocarditis and degeneration of the myocardium.

A2.8.1.8. Cardiomyopathy, any etiology, including hypertrophic obstructive type, idiopathic dilated type, toxic, restrictive.

A2.8.1.9. Endocarditis, infectious (acute or subacute), and marantic.

A2.8.1.10. Pericarditis.

A2.8.1.10.1. Chronic constrictive pericarditis, unless successful surgery has been performed and return of normal hemodynamics objectively documented.

A2.8.1.10.2. Chronic serous pericarditis.

A2.8.1.11. Acute rheumatic valvulitis or sequelae of chronic rheumatic heart disease (see also, valvular heart disease below).

A2.8.1.12. Premature ventricular contractions. When they interfere with the satisfactory performance of duty.

A2.8.1.13. Atrioventricular block, other than first degree or asymptomatic Type I second degree Atrioventricular (AV) block without structural heart disease. Higher degrees of block must be individually evaluated, even if asymptomatic.

A2.8.1.14. Peripheral vascular disease, if symptomatic, including claudication, skin changes or cerebrovascular events.

A2.8.1.15. Periarteritis nodosa.

A2.8.1.16. Chronic venous insufficiency (postphlebitic syndrome). When symptomatic or requiring elastic support or chronic anticoagulation.

A2.8.1.17. Raynaud's phenomenon, if frequent, severe, associated with systemic disease or would limit worldwide assignability.

A2.8.1.18. Thromboangiitis obliterans.

A2.8.1.19. Deep venous thrombosis with repeated attacks requiring treatment or prophylaxis, or pulmonary embolus.

A2.8.1.20. Varicose veins. Severe and symptomatic.

A2.8.1.21. Congenital anomalies. Coarctation of aorta, atrial or ventricular septal defect and other congenital anomalies unless satisfactorily treated by surgical correction.

A2.8.1.22. Valvular heart disease, including:

A2.8.1.22.1. Symptomatic mitral valve prolapse requiring treatment.

A2.8.1.22.2. Moderate to severe aortic stenosis (valvular, subvalvular or supravalvular), even if asymptomatic.

A2.8.1.22.3. Moderate to severe mitral regurgitation, any etiology, if symptomatic or associated with subnormal ejection fraction. Successful mitral repair with preservation of ejection fraction, no need for anticoagulants or anti-arrhythmics may be waived if exercise tolerance is normal, but MEB processing should precede surgery.

A2.8.1.22.4. Severe valvular or subvalvular pulmonic stenosis. Successful correction of valvular pulmonic stenosis with balloon valvuloplasty may be waiverable, but MEB processing should precede the procedure.

A2.8.1.22.5. Symptomatic mitral stenosis generally associated with mitral valve area less than 1.0 cm sq.

A2.8.1.22.6. Severe aortic insufficiency if symptomatic associated with left ventricular dilation or dysfunction.

A2.8.2. Hypertensive cardiovascular disease.

A2.8.2.1. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status or history of hypertension associated with any of the following:

A2.8.2.1.1. More than minimal demonstrable changes in the brain.

A2.8.2.1.2. Heart disease related to the hypertension, including atrial fibrillation, moderate to severe left ventricular hypertrophy, and symptomatic systolic or diastolic dysfunction.

A2.8.2.1.3. Unequivocal impairment of renal function.

A2.8.2.1.4. Grade III (Keith-Wagener-Parker) changes in the fundi.

A2.8.2.1.5. Multiple drug therapy with the requirement for an inordinate amount of medical supervision.

A2.8.2.2. Aneurysm or history of repair.

A2.8.2.3. Reconstructive surgery, including:

A2.8.2.3.1. Grafts.

A2.8.2.3.2. Prosthetic devices that are attached to or implanted for cardiovascular therapeutic purposes, regardless of result. Intracoronary stents may, in certain instances, be acceptable without MEB if associated with a good result, no myocardial infarction has occurred, and a six-month post-procedure treadmill is non-ischemic. Worldwide Duty Medical Processing is required for ARC members 6-12 months following procedure with associated myocardial damage; three months if no myocardial damage.

A2.8.2.3.3. Surgery of the heart, pericardium, or vascular system.

A2.8.2.3.4. Member has undergone coronary vascular surgery, regardless of the result. Coronary angioplasty, may in certain instances, be acceptable without MEB if no myocardial infarction has occurred, a good result is obtained, and six month post-procedure treadmill or equivalent test is non-ischemic.

***NOTES:***

1. Conditions above must have MEB processing within 90 calendar days of surgery regardless of the results, unless stated otherwise.
2. Refer to **Chapter 5** when managing cases on ARC members.

**A2.9. Blood, Blood-Forming Tissue, and Immune System Diseases.**

A2.9.1. Anemia, symptomatic.

A2.9.2. Leucopenia, chronic.

A2.9.3. Hemolytic disease, chronic. Symptomatic or with recurrent crises.

A2.9.4. Polycythemia, symptomatic.

A2.9.5. Purpura and other bleeding disorders.

A2.9.6. Thromboembolic disease.

A2.9.7. Splenomegaly, chronic, inoperable.

A2.9.8. Other such diseases when response to therapy is unsatisfactory or when therapy is prolonged or requires intense medical supervision such as use of anticoagulants other than aspirin or persantine.

A2.9.9. Leukemia.

A2.9.10. Immunodeficiency.

A2.9.11. Sickle cell disease and heterozygous sickling disorders other than sickle cell trait are disqualifying.

***NOTE:*** Those individuals with sickling disorders who develop symptoms attributable to the trait must undergo MEB evaluation. (Refer to paragraph **4.11.2.** for ARC members).

**A2.10. Abdomen and Gastrointestinal System.**

A2.10.1. Esophageal.

A2.10.1.1. Achalasia (cardiospasm), manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

A2.10.1.2. Esophagitis, persistent and severe.

A2.10.1.3. Diverticulum of the esophagus that causes frequent regurgitation, obstruction, and weight loss, and does not respond to treatment.

A2.10.1.4. Stricture of the esophagus that requires an essentially liquid diet, frequent dilation and hospitalization, and causes difficulty in maintaining weight and nutrition.

A2.10.1.5. Other recurrent, incapacitating abdominal pain of such nature to prevent the member from performing his/her duties.

A2.10.2. Gastritis. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

A2.10.3. Hernia.

A2.10.3.1. Hiatus hernia with severe symptoms not relieved by dietary or medical therapy or with recurrent bleeding in spite of prescribed therapy.

A2.10.3.2. Other types of hernias, if operative repair is contraindicated for medical reasons, or if not amenable to surgical repair.

A2.10.4. Ulcer. Peptic, duodenal or gastric with repeated incapacitations or absences from duty because of recurrence of symptoms despite good medical management and supported by laboratory and X-ray evidence of activity or severe deformity.

A2.10.5. Cirrhosis of the liver. Recurrent jaundice or ascites or demonstrable esophageal varices or history of bleeding from them.

A2.10.6. Hepatitis. Chronic, when symptoms persist after a reasonable time following the acute stage and there is objective evidence of impairment of liver function.

A2.10.7. Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

A2.10.8. Pancreatitis, chronic. Recurrent pseudocystitis or frequent abdominal pain requiring hospitalization or steatorrhea, or disturbance of glucose metabolism requiring insulin.

A2.10.9. Peritoneal adhesions. Recurring episodes of intestinal obstruction, characterized by abdominal colicky pain, and vomiting, and requiring frequent admissions to the hospital.

A2.10.10. Granulomatous enteritis or enterocolitis or Crohn's disease.

A2.10.11. Ulcerative colitis.

A2.10.12. Stricture of rectum. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, and difficult bowel movements that require the regular use of laxatives, enemas, or repeated hospitalization.

A2.10.13. Proctitis, chronic. Moderate to severe symptoms of bleeding, painful defecation, or tenesmus, and diarrhea with repeated admissions to the hospital.

A2.10.14. Anus. Impairment of sphincter control with fecal incontinence.

A2.10.15. Familial polyposis.

A2.10.16. Surgery.

A2.10.16.1. Colectomy, partial, when more than mild symptoms of diarrhea remain.

A2.10.16.2. Colostomy, when permanent.

A2.10.16.3. Enterostomy, when permanent.

A2.10.16.4. Gastrectomy, total.

A2.10.16.5. Gastrectomy, subtotal with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when, in spite of good medical management, the individual:

A2.10.16.5.1. Develops incapacitating dumping syndrome.

A2.10.16.5.2. Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

A2.10.16.5.3. Continues to demonstrate significant weight loss.

A2.10.16.6. Gastrostomy, when permanent.

A2.10.16.7. Ileostomy, when permanent.

A2.10.16.8. Pancreatectomy, except for partial pancreatectomy for a benign condition that does not result in moderate residual symptoms.

A2.10.16.9. Pancreaticoduodenostomy, pancreaticogastrostomy, and pancreaticojejunostomy.

A2.10.16.10. Proctectomy.

A2.10.16.11. Proctoplexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after appropriate treatment.

A2.10.16.12. Gastrointestinal bypass or stomach stapling for control of obesity.

**A2.11. Genitourinary System.**

A2.11.1. Genitourinary Conditions.

A2.11.1.1. Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

A2.11.1.2. Dysmenorrhea. Not amenable to treatment, and incapacitating.

A2.11.1.3. Endometriosis. Symptomatic and incapacitating.

A2.11.1.4. Hypospadias. Not amenable to treatment.

A2.11.1.5. Incontinence of urine. Not amenable to treatment.

A2.11.1.6. Kidney:

A2.11.1.6.1. Calculus in kidney, symptomatic and incapacitating.

A2.11.1.6.2. Congenital anomaly, resulting in frequent or recurring infections or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

A2.11.1.6.3. Cystic kidney (polycystic kidney), when renal function is impaired, or is the focus of frequent infection.

A2.11.1.6.4. Hydronephrosis, more than mild, and causing continuous or frequent symptoms.

A2.11.1.6.5. Hypoplasia of the kidney, associated with elevated blood pressure or frequent infections or reduction in renal function.

A2.11.1.6.6. Nephritis, chronic, with renal function impairment.

A2.11.1.6.7. Nephrosis, other than mild.

A2.11.1.6.8. Pyelonephritis or pyelitis, chronic, which has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

A2.11.1.7. Menopausal or premenstrual syndrome. Physiologic or artificial, significantly interfering with the satisfactory performance of duty.

A2.11.1.8. Strictures of the urethra or ureter. Severe and not amenable to treatment.

A2.11.1.9. Urethritis. Chronic, not responsive to treatment and necessitating frequent absences from duty.

A2.11.2. Genitourinary and Gynecological Surgery.

A2.11.2.1. Cystectomy.

A2.11.2.2. Cystoplasty. If reconstruction is unsatisfactory, or if refractory symptomatic infections persist.

A2.11.2.3. Nephrectomy. When after treatment, there is infection or pathologic change (anatomic or functional) in the remaining kidney.

A2.11.2.4. Nephrostomy or pyelostomy, if drainage persists.

A2.11.2.5. Gonadectomy. Bilateral, when following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

A2.11.2.6. Penis. Amputation of. When urine is voided in such a manner that clothing or surroundings are soiled, or results in severe mental symptoms.

A2.11.2.7. Ureterointestinal or direct cutaneous urinary diversion.

A2.11.2.8. Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

A2.11.2.9. Ureteroplasty.

A2.11.2.9.1. When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for nephrectomy.

A2.11.2.9.2. When bilateral and surgical repair is unsuccessful and associated with significant complications or sequelae (for example, hydronephrosis, residual obstruction or therapeutically refractive pyelonephritis).

A2.11.2.10. Ureterosigmoidostomy.

A2.11.2.11. Ureterostomy. External or cutaneous.

A2.11.2.12. Urethrostomy. External or when a satisfactory urethra cannot be restored.

A2.11.2.13. Major abnormalities and defects of the genitalia such as change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.). Residual to surgical corrections of these conditions.

**A2.12. Neurologic Disorders.**

A2.12.1. Amyotrophic lateral sclerosis.

A2.12.2. Myelopathic muscular atrophy, including residuals of poliomyelitis.

A2.12.3. Progressive muscular atrophy.

A2.12.4. Chorea. Chronic and progressive.

A2.12.5. Friedreich's ataxia.

A2.12.6. Hepatolenticular degeneration.

A2.12.7. Seizure disorder.

A2.12.7.1. For Active Duty, MEB processing must be done within 90 calendar days of the first episode.

A2.12.7.2. For ARC members, refer to paragraph **4.11.2.**

A2.12.7.3. Seizures following omission of prescribed medication or ingestion of alcoholic beverages are not indicative of the controllability of the disorder.

A2.12.8. Migraine. Manifested by frequent disabling attacks, which last for several consecutive days, and are unrelieved by treatment.

A2.12.9. Multiple sclerosis.

A2.12.10. Myasthenia gravis.

A2.12.11. Transverse myelopathy.

A2.12.12. Narcolepsy, when not controlled by non-schedule 2 medications.

A2.12.13. Paralysis agitans.

A2.12.14. Peripheral nerve conditions such as:

A2.12.14.1. Neuralgia, when symptoms are severe, persistent, and do not respond to treatment.

A2.12.14.2. Neuritis or paralysis due to peripheral nerve injury, when manifested by more than moderate, permanent functional impairment.

A2.12.15. Syringomyelia.

A2.12.16. Other neurological conditions. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech, or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

**A2.13. Axis I Diagnosis, and Other Mental Conditions.** MEB is indicated in those instances when a mental health condition precludes satisfactory performance of duty or worldwide assignability. An MEB must be done when a condition has caused or is expected to cause significant duty impairment or limitations for greater than one year and for conditions in which there is recurrent impairment or recurrent impairment is expected. Certain Axis I conditions make an airman unfit for duty and subject to MEB (refer to **A2.13.2.5.**). Axis II conditions can make a person unsuitable for further military service and subject to administrative separation. Incapacity because of illness (unfit for duty) must be distinguished from lack of motivation or underlying personality disorder (unsuitable for duty). Axis II conditions, when present with an Axis I condition can clearly worsen overall impairment and prognosis. MEB evaluation is required in those instances when an Axis I or Axis I combined with Axis II condition precludes satisfactory performance of duty or worldwide assignability. If a diagnosis which questions fitness for duty (Axis I) is made while a member is pending administrative separation, the member's commander contacts the local MPF and Staff Judge Advocate for specific guidance.

A2.13.1. Any psychotic episode other than those with a brief duration, good prognosis and clearly identifiable and reversible cause should meet MEB.

A2.13.2. Mental conditions requiring MEB:

A2.13.2.1. Conditions that are expected to have persistent duty impairment (more than 1 year despite treatment).

A2.13.2.2. Conditions associated with recurrent duty impairment (2 or more episodes of impairment in 12 months).

A2.13.2.3. Conditions which require continuing psychiatric support (e.g. weekly psychotherapy in order to function) beyond one year.

A2.13.2.4. Conditions requiring use of lithium, anticonvulsants, or antipsychotics for mood stabilization.

A2.13.2.5. Individuals who experience recurrent depression or anxiety disorders, require psychiatric medication for greater than one year, who have been hospitalized for a psychiatric condition, or who have attempted suicide require an evaluation by a military mental health provider to determine whether or not a MEB is necessary. These cases warrant careful consideration of fitness for duty, worldwide assignability and deployability, given that adequate mental health support may not be available in all locations. Serious psychiatric illnesses (refer to criteria in **A2.13.2.1.-A2.13.2.4.** above) that result in hospitalization or a suicide attempt require a MEB. For ANG members on long-term antidepressant maintenance therapy even if asymptomatic or in remission, a WWD evaluation must still be forwarded to ANG/SGPA for consideration.

***NOTE:*** ARC members with an axis I diagnosis will receive a world-wide duty evaluation. Reserve providers should look closely at any member on psychotropic drugs to determine if any axis I diagnosis exists. For AFRC members on psychotropic drugs for non-psychiatric diagnosis do not need a worldwide duty evaluation based on this section. For ANG members on SSRI medication for non-Axis II dx for up to 90 days do not require a WWD evaluation. For all other questionable cases, please forward to ANG/SGPA for determination.

A2.13.3. Certain psychiatric disorders render an individual unsuited for duty, rather than unfit, and are subject to administrative separation (IAW AFI 36-3208, para 5.11).

A2.13.3.1. Alcoholism or illegal drug use is likely to render an individual unsuitable and subject to administrative separation. Provisions for rehabilitation and disposition are in appropriate directives (IAW AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program).* MEB evaluations are indicated only in those instances where drug dependency is the proximate result of a current or pre-existing Axis I condition or in those instances when medical complications or sequelae of alcoholism or drug use (for example, recurrent jaundice or ascites, esophageal varices, chronic pancreatitis, organic central nervous system (CNS) disorders, etc.) preclude satisfactory performance of duty and worldwide assignability.

A2.13.3.2. Unsatisfactory duty performance due to personality disorders, adjustment disorders or sexual perversions may render an individual unsuitable as opposed to unfit and subject to administrative separation. Consult legal for further disposition and clarification.

A2.13.3.3. Mental Conditions Considered Administrative. Alcoholism or illegal drug use is likely to render an individual unsuitable and subject to administrative separation. Provisions for rehabilitation and disposition are in appropriate directives. (see AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program)* MEB evaluations are indicated only in those instances where drug dependency is the proximate result of a current or pre-existing Axis I condition or in those instances when medical complications or sequelae of alcoholism or drug use (for example, recurrent jaundice or ascites, esophageal varices, chronic pancreatitis, organic central nervous system (CNS) disorders, etc.) preclude satisfactory performance of duty and worldwide assignability.

A2.13.4. Unsatisfactory duty performance due to disorders of character or behavior (Personality disorders), adjustment disorders or sexual perversions may render an individual unsuitable as opposed to unfit and subject to administrative separation. Consult legal for further disposition and clarification.

A2.13.5. Learning Disorders - Individuals determined to have a primary mental deficiency or special learning defect which interferes with the satisfactory performance of duty are unsuitable and subject to administrative separation. Learning disorders that interfere with effective duty performance are dealt with through administrative channels.

A2.13.6. Attention Deficit Hyperactivity Disorder (ADHD). Individuals diagnosed with ADHD should be carefully evaluated for suitability for continued service. Members with this condition do not merit a medical board disposition and may be managed administratively. If treatment with medication is required for adequate duty performance, referral to the unit commander for determination of administrative disposition is appropriate. The commander may seek administrative separation based on impaired performance or allow for continued duty if the value to the unit outweighs risks of requiring medication. If treatment with medication is not required for adequate duty performance, the member remains suited for continued military service.

A2.13.7. "Flying phobia" of sufficient magnitude to preclude military air transportation is dealt with administratively unless the condition is the proximate result of an Axis I condition other than simple phobia.

**A2.14. Extremities.**

A2.14.1. Upper extremities.

A2.14.1.1. Amputation of part or parts of an upper extremity that results in impairment equivalent to the loss of use of a hand.

A2.14.1.2. Joint ranges of motion, which do not equal or exceed the following:

A2.14.1.3. For shoulder:

A2.14.1.3.1. Forward elevation to 90 degrees.

A2.14.1.3.2. Abduction to 90 degrees.

A2.14.1.4. For elbow:

A2.14.1.4.1. Flexion to 100 degrees.

A2.14.1.4.2. Extension to 45 degrees of flexion.

A2.14.1.5. Chronic dislocation, when not reparable or when surgery is contraindicated.

A2.14.2. Lower Extremities.

A2.14.2.1. Hip dislocation.

A2.14.2.2. Amputation of a toe or toes that precludes the ability to run or walk without a perceptible limp or to perform duty in a satisfactory manner.

A2.14.2.3. Any loss greater than specified above to include foot, leg, or thigh.

A2.14.2.4. Feet:

A2.14.2.4.1. Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms, or severe with arthritic changes.

A2.14.2.4.2. Pes planus, symptomatic, more than moderate with pronation on weight bearing which prevents the wearing of a military shoe, or when associated with trophic changes.

A2.14.2.4.3. Talipes cavus when severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or which prevents the wearing of a military shoe.

A2.14.2.5. Internal derangement of the knee.

A2.14.2.5.1. Residual instability following remedial measures if more than moderate in degree or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

A2.14.2.5.2. If complicated by arthritis.

A2.14.2.6. Joint Ranges of Motion. Motion that does not equal or exceed the measurements listed below:

A2.14.2.6.1. Hip.

Flexion to 90 degrees.

Extension to 0 degrees.

A2.14.2.6.2. Knee.

Flexion to 90 degrees.

Extension to 15 degrees.

A2.14.2.6.3. Shortening of an extremity, which exceeds 5 centimeters (2 inches).

A2.14.2.7. Miscellaneous.

A2.14.2.7.1. Arthritis.

A2.14.2.7.1.1. Arthritis due to infection associated with persistent pain and marked loss of function, with X-ray evidence, and documented history of recurrent incapacitation.

A2.14.2.7.1.2. Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joint so as to preclude satisfactory performance of duty.

A2.14.2.7.1.3. Osteoarthritis, with severe symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

A2.14.2.7.1.4. Rheumatoid arthritis or rheumatoid myositis, with substantiated history of frequent incapacitating episodes supported by objective and subjective findings.

A2.14.2.7.2. Chondromalacia or Osteochondritis dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

A2.14.2.7.3. Fractures.

A2.14.2.7.3.1. Malunion when, after appropriate treatment, there is severe malunion with marked deformity or more than moderate loss of function.

A2.14.2.7.3.2. Nonunion when, after an appropriate healing period, the nonunion persists with severe loss of function.

A2.14.2.7.3.3. Bone fusion defect when manifested by severe pain or loss of function.

A2.14.2.7.3.4. Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

A2.14.2.7.4. Joints.

A2.14.2.7.4.1. Arthroplasty, with severe pain, limitation of motion, and limitation of function, joint prosthesis or total joint replacement.

A2.14.2.7.4.2. Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments, or ankylosis in unfavorable positions or ankylosis with marked loss of function.

A2.14.2.7.4.3. Contracture with marked loss of function and the condition is not remediable by surgery.

A2.14.2.7.4.4. Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

A2.14.2.7.5. Muscles. Flaccid or spastic paralysis or loss of substance of one or more muscles, producing loss of function, which precludes satisfactory performance of military duty.

A2.14.2.7.5.1. Myotonia congenita, significantly symptomatic.

A2.14.2.7.6. Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

A2.14.2.7.7. Osteoarthropathy. Hypertrophic, secondary, with severe pain in one or multiple joints and with moderate loss of function.

A2.14.2.7.8. Osteomyelitis, chronic. Recurrent episodes not responsive to treatment or involving the bone to a degree that interferes with stability and function.

A2.14.2.7.9. Tendon transplant. Unsatisfactory restoration of function.

**A2.15. Spine, Scapulae, Ribs, and Sacroiliac Joints.**

A2.15.1. Congenital anomalies presenting functional impairment of a degree to preclude the satisfactory performance of duty.

A2.15.2. Spina bifida, with demonstrable signs and moderate symptoms of root or cord involvement.

A2.15.3. Coxa vara, more than moderate with pain, deformity and arthritic changes.

A2.15.4. Herniation of nucleus pulposus, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

A2.15.5. Spondylolysis or spondylolisthesis, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

A2.15.6. Deviation or curvature of spine. More than moderate, or interfering with function or causing unmilitary appearance.

**A2.16. Skin and Cellular Tissues.**

A2.16.1. Acne, severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wear of the uniform or use of military equipment.

A2.16.2. Atopic dermatitis, severe or requiring frequent hospitalization.

A2.16.3. Cysts and tumors. Refer to paragraph **A2.19.**

A2.16.4. Dermatitis herpetiformis, which fails to respond to therapy.

A2.16.5. Eczema, chronic, regardless of type, when there is moderate involvement or when there are repeated exacerbations in spite of continuing treatment.

A2.16.6. Elephantiasis or chronic lymphedema, not responsive to treatment.

A2.16.7. Epidermolysis bullosa.

A2.16.8. Erythema multiforme, severe, and chronic or recurrent.

A2.16.9. Exfoliative dermatitis, chronic.

A2.16.10. Fungus infections, superficial, if not responsive to therapy and resulting in frequent absences from duty.

A2.16.11. Hidradenitis, suppurative, and folliculitis decalvans.

A2.16.12. Hyperhidrosis of the hands or feet when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

A2.16.13. Leukemia cutis and mycosis fungoides.

A2.16.14. Lichen planus, generalized and not responsive to treatment.

A2.16.15. Lupus erythematosus, chronic discoid variety with extensive involvement or when the condition does not respond to treatment.

A2.16.16. Neurofibromatosis, if disfigurement is extensive or when associated with manifestation of other organ system involvement.

A2.16.17. Pemphigus, not responsive to treatment and with moderate constitutional or systemic symptoms.

A2.16.18. Psoriasis or parapsoriasis, extensive and not controlled by treatment or controllable only with potent cytotoxic agents.

A2.16.19. Radiodermatitis, if resulting in malignant degeneration at a site not amenable to treatment.

A2.16.20. Scars and keloids, so extensive they seriously interfere with the function of the body area or they interfere with proper fit and wear of military equipment.

A2.16.21. Tuberculosis of the skin, if not responsive to therapy. Refer to paragraph **A2.19.**

A2.16.22. Ulcers of the skin, not responsive to treatment after an appropriate period of time or if they result in frequent absences from duty.

A2.16.23. Urticaria, chronic, severe, and not amenable to treatment.

A2.16.24. Other skin diseases, if chronic or of a nature that requires frequent medical care or interferes with the satisfactory performance of military duty.

**A2.17. Endocrine and Metabolic Conditions.**

A2.17.1. Acromegaly.

A2.17.2. Adrenal hyperfunction, not responding to therapy.

A2.17.3. Adrenal hypofunction.

A2.17.4. Diabetes insipidus, requiring antidiuretic hormone replacement therapy.

A2.17.5. Diabetes mellitus, diagnosed, including diet controlled and those requiring insulin or oral hypoglycemic drugs, MEB processing is done within 90 calendar days. For disposition of ARC members refer to **Chapter 4.**

***NOTE:*** The criteria for the diagnosis of diabetes (refer to **Chapter 4**) consist of (a) diabetic symptoms with a casual glucose greater than or equal to 200 mg/dl, (b) Fasting plasma glucose greater than or equal to 126 mg/dl, or (c) 2 hour plasma glucose greater than or equal to 200 mg/dl during an OGTT. The diagnosis is considered provisional until confirmed by any of these methods on a subsequent day. Values for fasting plasma glucose greater than or equal to 110 but less than 126 mg/dl are considered to represent impaired fasting glucose; 2 hours post-prandial glucose levels greater than or equal to 140 but less than 200 mg/dl represent impaired glucose tolerance.

A2.17.6. Gout, with frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

A2.17.7. Hyperinsulinism, when caused by a malignant tumor, or when the condition is not readily controlled.

A2.17.8. Hyperparathyroidism, when residuals or complications such as renal or bony defects preclude satisfactory performance of military duty.

A2.17.9. Hyperthyroidism, with severe symptoms that do not respond to treatment.

A2.17.10. Hypoparathyroidism, with objective evidence and severe symptoms not controlled by maintenance therapy.

A2.17.11. Osteomalacia, when residuals after therapy are of such degree or nature as to limit physical activity to a significant degree.

**A2.18. Systemic Disease.**

A2.18.1. HIV seropositivity, confirmed.

A2.18.2. Amyloidosis, generalized.

A2.18.3. Dermatomyositis polymyositis complex.

A2.18.4. Leprosy, any type.

A2.18.5. Lupus erythematosus, disseminated, chronic.

A2.18.6. Myasthenia gravis.

A2.18.7. Mycoses, active, not responsive to therapy, or requiring prolonged treatment, or when complicated by disqualifying residuals.

A2.18.8. Panniculitis, relapsing, febrile, nodular.

A2.18.9. Porphyria.

A2.18.10. Sarcoidosis, progressive, with severe or multiple organ involvement and not responsive to therapy (see paragraph **A2.7.**).

A2.18.11. Scleroderma, Generalized or of the linear type which seriously interferes with the function of an extremity or body area involved or progressive systemic sclerosis including CREST Syndrome (calcinosis, Raynaud's phenomenon, esophageal hypomotility, sclerodactyly, and telangiectasia).

A2.18.12. Tuberculosis, Generalized.

**A2.19. Tumors and Malignant Diseases.**

A2.19.1. Malignant neoplasms or residuals of treatment.

A2.19.2. Neoplastic conditions of lymphoid and blood-forming tissues.

A2.19.3. Benign neoplasms, when the condition prevents the satisfactory performance of duty and the condition is not remediable or a remedial operation is refused.

***NOTE:*** All members with neoplastic disease must meet an MEB within 90 calendar days of initial diagnosis or as soon as the medical condition has stabilized. Basal cell, squamous cell carcinoma and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which has been treated by electrodessication and curettage by a dermatologist credentialed to perform the procedure) are exempted from Tumor Board Action and do not require MEB. For ARC members, refer to paragraph **4.11.2.**

**A2.20. Sexually Transmitted Diseases.**

A2.20.1. Symptomatic neurosyphilis, in any form.

A2.20.2. Complications or residual of sexually transmitted disease, of such chronicity or degree of severity the individual is incapable of performing duty.

**A2.21. General and Miscellaneous Conditions and Defects.**

A2.21.1. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.

A2.21.2. The individual's health or well-being would be compromised if he or she were to remain in the military service.

A2.21.3. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases are referred to MEB or to the appropriate ARC surgeon for those ARC members who are not on EAD and are not authorized disability processing.

A2.21.4. The individual has an EPTS defect or condition for which corrective surgery is contemplated.

A2.21.5. The individual requires an indefinite (permanent) excusal from fitness testing.

A2.21.6. The individual's travel by military air transportation is precluded for medical reasons. (See paragraph **A2.13.** concerning "flying phobia").

A2.21.7. The individual has an assignment canceled due to a medical condition. Present to an MEB, or within 10 calendar days, provide narrative summary to HQ AFPC/DPAMM for review in lieu of MEB.

A2.21.8. The individual continues to have a 4-T profile 1 year after the defect became disqualifying and has not yet met an MEB.

A2.21.9. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. MEB should be accomplished when the patient's future qualification for further military service is foreseeable and should not be delayed until receipt of maximum hospital benefit.

A2.21.10. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures.

A2.21.11. The individual requires determination of his or her competency for pay purposes.

A2.21.12. The individual has had a sanity determination required by the Manual for Courts-Martial and the psychiatric findings indicate the member's suitability for continued military service is questionable.

A2.21.13. The individual has coexisting medical defects that are thought to be the primary cause of unacceptable behavior or unsatisfactory performance.

A2.21.13.1. If an individual's commander feels that a medical condition causes sufficient absences from duty that interferes with mission accomplishment, the commander may at their discretion request medical evaluation to determine fitness for continued military service.

A2.21.14. Inability to receive all mobility required immunization.

***NOTE:*** e.g. anthrax and smallpox immunizations are required for some, but not all deployments. If an individual must deploy to a location requiring either or both of these immunizations and is unable to take these immunizations, a waiver for deployment without these immunizations can be obtained from the gaining theater commander if the individual agrees to accept the increased risk.

A2.21.15. Allergic manifestations: A reliable history of generalized reaction with anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices or food additives.

## Attachment 3

## MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

**A3.1. Conditions listed in Attachment 2, Medical Standards for Continued Military Service (Retention) also apply. These standards are not all inclusive and other diseases or defects not specifically listed can be cause for rejection based upon the medical judgment of the examining physician or reviewing authority.**

### A3.2. Head.

A3.2.1. Uncorrected deformities of the skull, face, or mandible (754.0) of a degree that shall prevent the individual from the wearing a protective mask or military headgear is disqualifying.

A3.2.2. Loss, or absence of the bony substance of the skull (756.0 or 738.1) not successfully corrected by reconstructive materials, or leaving residual defect in excess of one square inch (6.45$cm^2$) or the size of a 25-cent piece is disqualifying.

### A3.3. Neck.

A3.3.1. Current symptomatic cervical ribs (756.2) are disqualifying.

A3.3.2. Current or history of congenital cyst(s) (744.4) of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts is disqualifying.

A3.3.3. Current contraction (723) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it interferes with the proper wearing of a uniform or military equipment or is so disfiguring as to interfere with or prevent satisfactory performance of military duty is disqualifying.

### A3.4. Mouth.

A3.4.1. Current cleft lip or palate defects (749) not satisfactorily repaired by surgery is disqualifying.

A3.4.2. Current leukoplakia (528.6) is disqualifying.

### A3.5. Nose and Sinuses.

A3.5.1. Rhinitis.

A3.5.1.1. Current allergic rhinitis (477.0) due to pollen (477.8) or due to other allergen or cause unspecified (477.9) if not controlled by oral medication or topical corticosteroid medication is disqualifying. History of allergic rhinitis immunotherapy within the previous year is disqualifying.

A3.5.1.2. Current chronic non-allergic rhinitis (472.0) if not controlled by oral medication, or topical corticosteroid medication is disqualifying.

A3.5.2. Current anosmia or parosmia (781.1) is disqualifying.

A3.5.3. History of recurrent epistaxis with greater than one episode per week of bright red blood from the nose occurring over a 3-month period (784.7) is disqualifying.

A3.5.4. Current nasal polyp or history of nasal polyps (471), unless greater than 12 months has elapsed since nasal polypectomy is disqualifying.

A3.5.5. Current perforation of nasal septum (478.1) is disqualifying.

A3.5.6. Current chronic sinusitis (473) or current acute sinusitis (461.9) is disqualifying. Such conditions exist when evidenced by chronic purulent nasal discharge, hyperplastic changes of the nasal tissue, symptoms requiring frequent medical attention or x-ray findings.

**A3.6. Pharynx, Trachea, and Larynx.**

A3.6.1. Current chronic conditions of larynx including vocal cord paralysis (478.3), chronic hoarseness, chronic laryngitis, larynx ulceration, polyps, granulation tissue, or other symptomatic disease of larynx, vocal cord dysfunction not elsewhere classified (478.7) are disqualifying.

A3.6.2. Current or history of tracheostomy (V44.0) or tracheal fistula (530.84) is disqualifying.

**A3.7. Other Defects and Diseases of the Mouth, Nose, Throat, Pharynx, Trachea, and Larynx.**

A3.7.1. Current or history of deformities or conditions or anomalies of upper alimentary tract (750.9), of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech or breathing are disqualifying.

A3.7.2. Current chronic pharyngitis (462) and chronic nasopharyngitis (472.2) are disqualifying.

**A3.8. Ears.**

A3.8.1. Auricle, Mastoids, and Outer Ear.

A3.8.1.1. Current atresia of the external ear (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5), chronic otitis externa (380.2), severe external ear deformity (744.3) that prevents or interferes with the proper wearing of hearing protection is disqualifying.

A3.8.1.2. Current or history of mastoiditis (383.9), residual with fistula (383.81), chronic drainage or conditions requiring frequent cleaning of the mastoid bone is disqualifying.

A3.8.1.3. Current or history of Meniere's Syndrome or other chronic diseases of the vestibular system (386) is disqualifying.

A3.8.2. Middle ear.

A3.8.2.1. Current or history of chronic otitis media (382) beyond the 13$^{th}$ birthday, of any type is disqualifying.

A3.8.2.2. Current or history of cholesteatoma (385.3) is disqualifying.

A3.8.2.3. History of middle (P19) ear surgery, excluding successful myringotomy, is disqualifying.

A3.8.3. Tympanic membrane and Inner Ear.

A3.8.3.1. Current perforation of the tympanic membrane (384.2) is disqualifying.

A3.8.3.2. Current or history of surgery to correct perforation in the preceding 120 days (P19) is disqualifying.

A3.8.3.3. Current or history of any inner (P20) ear surgery (including cochlear implantation) is disqualifying.

**A3.9. Hearing (All hearing defects are coded with ICD-9 code 389).** (See paragraph A3.8.)

A3.9.1. Audiometric Hearing Levels:

A3.9.1.1. Audiometers calibrated to the International Organization for Standardization (ISO 8253:1 1989) (reference (c)) or the American National Standards Institute (ANSI 1996) (reference (d)) shall be used to test the hearing of all applicants

A3.9.1.2. Current hearing threshold level in either ear greater than that described below is disqualifying:

A3.9.1.2.1. Pure tone at 500, 1000, and 2000 cycles per second for each ear of not more than 30 dB on the average with no individual level greater than 35 dB at these frequencies.

A3.9.1.2.2. Pure tone level not more than 45 dB at 3000 cycles per second or 55 dB at 4000 cycles per second for each ear.

A3.9.1.2.3. There is no standard for 6000 cycles per second.

A3.9.2. Current or history of hearing aid use (V53.2) is disqualifying.

**A3.10. Dental.**

A3.10.1. Current diseases of the jaw or associated tissues that prevent normal functioning are disqualifying. Those diseases include but are not limited to temporomandibular disorders (524.6) and/or myofascial pain that have not been corrected.

A3.10.2. Current severe malocclusion (524), which interferes with normal mastication or requires early and protracted treatment; or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement is disqualifying.

A3.10.3. Current insufficient natural healthy teeth (521) or lack of a serviceable prosthesis that prevents adequate incision and mastication of a normal diet and/or includes complex (multiple fixtures) dental implant systems with associated complications are disqualifying. Individuals undergoing endodontic care are acceptable for entry in the Delayed Entry Program only if a civilian or military provider provides documentation that active endodontic treatment shall be completed prior to being sworn into active duty.

A3.10.4. Current orthodontic appliances for continued treatment (V53.4) are disqualifying. Retainer appliances are permissible, provided all active orthodontic treatment has been satisfactorily completed. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program only if a civilian or military orthodontist provides documentation that active orthodontic treatment shall be completed prior to being sworn into active duty.

**A3.11. Eyes.**

A3.11.1. Lids.

A3.11.1.1. Current blepharitis (373.0), chronic or acute, until cured (373.00) is disqualifying.

A3.11.1.2. Current blepharospasm (333.81) is disqualifying.

A3.11.1.3. Current dacryocystitis, acute or chronic (375.30) is disqualifying.

A3.11.1.4. Deformity of the lids (374.4), complete or extensive lid deformity, sufficient to interfere with vision or impair protection of the eye from exposure is disqualifying.

A3.11.1.5. Current growth or tumor of the eyelid other than small, non-progressive asymptomatic benign lesions are disqualifying. Also, see paragraph **A3.32.**

A3.11.2. Conjunctiva.

A3.11.2.1. Current chronic conjunctivitis (372.1), including but not limited to trachoma (076) and chronic allergic conjunctivitis (372.14) is disqualifying.

A3.11.2.2. Pterygium.

A3.11.2.2.1. Recurring pterygium (372.4) after two operative procedures (372.45) is disqualifying.

A3.11.2.2.2. Current or recurrent pterygium (372.4) if condition encroaches on the cornea in excess of 3 millimeters, interfers with vision, or is a progressive peripheral pterygium (372.42) (as evidenced by marked vascularity on a thickened elevated head) is disqualifying.

A3.11.2.3. Current xerophthalmia (372.53) is disqualifying.

A3.11.3. Cornea.

A3.11.3.1. Current or history of corneal dystrophy of any type (371.5), including but not limited to keratoconus (371.6) of any degree, is disqualifying.

A3.11.3.2. History of refractive surgery including, but not limited to: Lamellar (P11.7) and/or penetrating keratoplasty (P11.6), Radial Keratotomy (P11.7) and Astigmatic Keratotomy (P11.7) is disqualifying. Refractive surgery performed with an Excimer Laser, including but not limited to, Photorefractive Keratectomy (commonly known as PRK) (P11.7), Laser Epithelial Keratomileusis (commonly known as LASEK) (P11.7) and Laser-Assisted in situ Keratomileusis (commonly known as LASIK) (P11.7) is disqualifying if any of the following conditions are met:

A3.11.3.2.1. Pre-surgical refractive error in either eye exceeded +8.00 to -8.00 diopters.

A3.11.3.2.2. At least 6 months recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.

A3.11.3.2.3. There have been complications (as listed below, to include but not limited to) and/or medications or ophthalmic solutions are required:

A3.11.3.2.3.1. Persistent glare.

A3.11.3.2.3.2. Persistent corneal haze beyond trace.

A3.11.3.2.3.3. Persistent halos.

A3.11.3.2.3.4. Diplopia (368.2).

A3.11.3.2.3.5. Persistent night vision difficulties.

A3.11.3.2.3.6. Severe dry eyes.

A3.11.3.2.3.7. Current corneal irregularity.

A3.11.3.2.4. Post-surgical refraction in each eye is not stable as demonstrated by:

A3.11.3.2.4.1. At least two separate refractions at least one month apart, the most recent of which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.25 diopters for cylinder vision; and

A3.11.3.2.4.2. At least 3 months recovery has not occurred between last refractive surgery or augmenting procedure and one of the comparison refractions.

A3.11.3.2.5. Post-surgical refractive error resulting in visual acuity that does not correct with spectacle lenses to 20/20 for each eye.

***NOTE:*** See also paragraph **A3.12.**

A3.11.3.3. Current keratitis (370), acute or chronic, including, but not limited to recurrent corneal ulcers (370.0), erosions, or herpetic ulcers (054.42) is disqualifying.

A3.11.3.4. Current corneal vascularization (370.6), or corneal opacification (371) from any cause that is progressive or reduces vision below the standards prescribed in paragraph **A3.12.** , is disqualifying.

A3.11.4. Uveal tract.

A3.11.4.1. Current or history of uveitis or iridocyclitis (364.3) is disqualifying.

A3.11.5. Retina.

A3.11.5.1. Current or history of retinal defects and dystrophies, angiomatoses (759.6), retinoschisis and retinal cysts (361.1), phakomas (362.89), and other congenito-retinal hereditary conditions (362.7) that impair visual function or are progressive, are disqualifying.

A3.11.5.2. Current or history of any chorioretinal or retinal inflammatory conditions, including, but not limited to conditions leading to neovascularization, chorioretinitis, histoplasmosis, toxoplasmosis, or vascular conditions of the eye to include Coats' Disease, or Eales' Disease (363) is disqualifying.

A3.11.5.3. Current or history of degenerative changes of any part of the retina (362) is disqualifying.

A3.11.5.4. Current or history of detachment of the retina (361), history of surgery for same, or peripheral retinal injury, defect (361.3), or degeneration that may cause retinal detachment is disqualifying.

A3.11.6. Optic nerve.

A3.11.6.1. Current or history of optic neuritis (377.3), including, but not limited to neuroretinitis, secondary optic atrophy, or documented history of retrobulbar neuritis is disqualifying.

A3.11.6.2. Current or history of optic atrophy (377.1) or cortical blindness (377.75) is disqualifying.

A3.11.6.3. Current or history of papilledema (377.0) is disqualifying.

A3.11.7. Lens.

A3.11.7.1. Current Aphakia (379.31), history of lens implant, or current or history of dislocation of a lens is disqualifying.

A3.11.7.2. Current or history of opacities of the lens (366) that interfere with vision or that are considered to be progressive, including cataract (366.9), are disqualifying.

A3.11.8. Ocular mobility and motility.

A3.11.8.1. Current diplopia (368.2) is disqualifying.

A3.11.8.2. Current nystagmus (379.50) other than physiologic end-point nystagmus is disqualifying.

A3.11.8.3. Esotropia (378.0) and hypertropia (378.31): For entrance into Service academies and officer programs, the individual Military Services may set additional requirements. The Military Services shall determine special administrative criteria for assignment to certain specialities.

A3.11.9. Miscellaneous defects and diseases.

A3.11.9.1. Current or history of abnormal visual fields due to diseases of the eye or central nervous system (368.4), or trauma (368.9) is disqualifying.

A3.11.9.2. Absence of an eye, clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.8) is disqualifying.

A3.11.9.3. Current asthenopia (368.13) is disqualifying.

A3.11.9.4. Current unilateral or bilateral non-familial exophthalmoses (376) are disqualifying.

A3.11.9.5. Current or history of glaucoma (365), including, but not limited to primary, secondary, or pre-glaucoma as evidenced by intraocular pressure above 21mmHg, or changes in the optic disc, or visual field loss associated with glaucoma, is disqualifying.

A3.11.9.6. Current loss of normal normal pupillary reflex, reactions to accommodation (367.5) or light (379.4), including Adie's Syndrome, is disqualifying.

A3.11.9.7. Current night blindness (368.60) is disqualifying.

A3.11.9.8. Current or history of retained intraocular foreign body (360) is disqualifying.

A3.11.9.9. Current or history of tumors. Also see paragraph **A3.32.**

A3.11.9.10. Current or history of any organic disease of the eye (360) or adnexa (376), with or without ocular surgery to include lasers of any type, not specified above, which threatens vision or visual function is disqualifying.

**A3.12. Vision.**

A3.12.1. Current distant visual acuity of any degree:

A3.12.1.1. Without history of corneal refractive surgery, which does not correct with spectacles to at least one of the following is disqualifying:

A3.12.1.1.1. 20/40 in one eye and 20/70 in the other eye.

A3.12.1.1.2. 20/30 in one eye and 20/100 in the other eye.

A3.12.1.1.3. 20/20 in one eye and 20/400 in the other eye.

A3.12.1.2. With history of corneal refractive surgery, which does not correct with spectacle lenses to 20/20 in each eye is disqualifying.

A3.12.2. Current near visual acuity of any degree:

A3.12.2.1. Without history of corneal refractive surgery, which does not correct to 20/40 in the better eye (367) is disqualifying.

A3.12.2.2. With history of corneal refractive surgery, which does not correct to 20/20 in each eye is disqualifying.

A3.12.3. Current refractive error, [hyperopia (367.0), myopia (367.1) astigmatism (367.2) ]or history of refractive error prior to any refractive surgery manifest by any refractive error in spherical equivalent of worse than –8.00 or +8.00 diopters is disqualifying.

A3.12.4. Current complicated cases requiring contact lenses for adequate correction of vision, such as corneal scars (371) and irregular astigmatism (367.2) are disqualifying.

A3.12.5. Color vision (368.5). Failure to pass a color vision test is not automatic disqualification. Although there is no standard, color vision will be tested, since adequate color vision is a prerequisite for entry into many military specialties.

**A3.13. Lungs, Chest Wall, Pleura, and Mediastinum.**

A3.13.1. Current abnormal elevation of the diaphragm (either side) is disqualifying. Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1), or other thoracic or abdominal organ (793.2) is disqualifying.

A3.13.2. Current abscess of the lung or mediastinum (513) is disqualifying.

A3.13.3. Current or history of acute infectious processes of the lung, including, but not limited to viral pneumonia (480), pneumococcal pneumonia (481), bacterial pneumonia (482), pneumonia other specified (483), pneumonia infectious disease classified elsewhere(484), bronchopneumonia organism unspecified (485), pneumonia organism unspecified (486), are disqualifying until cured.

A3.13.4. Asthma (493), including reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, reliably diagnosed and symptomatic after the 13$^{th}$ birthday is disqualifying. Reliable diagnostic criteria may include any of the following elements: Substantiated history of cough, wheeze, chest tightness and/or dyspnea which persists or recurs over a prolonged period of time generally more than 12 months.

A3.13.5. Current bronchitis (490), acute or chronic symptoms over 3 months occurring at least twice a year (491), is disqualifying.

A3.13.6. Current or history of bronchiectasis (494) is disqualifying.

A3.13.7. Current or history of bronchopleural fistula (510), unless resolved with no sequelae is disqualifying.

A3.13.8. Current or history of bullous or generalized pulmonary emphysema (492) is disqualifying.

A3.13.9. Current chest wall malformation (754), including, but not limited to pectus excavatum (754.81) or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion, is disqualifying.

A3.13.10. History of empyema (510) is disqualifying.

A3.13.11. Current pulmonary fibrosis from any cause, producing respiratory symptoms is disqualifying.

A3.13.12. Current foreign body in lung, trachea, or bronchus (934) is disqualifying.

A3.13.13. History of lobectomy (P32.4) is disqualifying.

A3.13.14. Current or history of pleurisy with effusion (511.9) within the previous 2 years is disqualifying.

A3.13.15. Current or history of pneumothorax (512) during the year preceding examination if due to trauma or surgery, or occurring during the 3 years preceding examination from spontaneous origin, is disqualifying. Recurrent spontaneous pneumothorax (512) is disqualifying.

A3.13.16. History of open or laparoscopic thoracic or chest wall (including breasts) surgery during the preceding 6 months (P54) is disqualifying.

**A3.14. Heart.**

A3.14.1. Current or history of all valvular heart diseases, congenital (746) or acquired (394) including those improved by surgery, are disqualifying. Mitral valve prolapse or bicuspid aortic valve is not disqualifying unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

A3.14.2. Current or history of coronary heart disease (410) is disqualifying.

A3.14.3. Current or history of symptomatic or electrocardiographic evidence of arrhythmia is disqualifying.

A3.14.4. Current or history of supraventricular tachycardia (427.0) or any arrhythmia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation unless there has been no recurrence during the preceding 2 years while off all medications is disqualifying.

A3.14.5. Current or history of premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment is disqualifying.

A3.14.6. Current or history of ventricular arrhythmias (427.1) including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions is disqualifying. Occasional asymptomatic unifocal premature ventricular contractions are not disqualifying.

A3.14.7. Current or history of ventricular conduction disorders, including but not limited to disorders with left bundle branch block (426.2), Mobitz type II second degree atrioventricular (AV) block (426.12), third degree AV block (426.0), and Lown-Ganong-Levine syndrome (426.81) associated with an arrhythmia are disqualifying. Current or history of Wolff-Parkinson-White syndrome (426.7), unless it has been successfully ablated for a period of 2 years without recurrence of arrhythmia and now with a normal electrocardiogram, is disqualifying.

A3.14.8. Current or history of conduction disturbances, such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4), or Mobitz type I second degree AV block (426.13) are disqualifying when symptomatic or associated with underlying cardiovascular disease.

A3.14.9. Current cardiomegaly, hypertrophy or dilation (429.3) of the heart is disqualifying.

A3.14.10. Current or history of cardiomyopathy (425), including myocarditis (422), or congestive heart failure (428), is disqualifying.

A3.14.11. Current or history of Pericarditis (acute nonrheumatic) (420), unless the individual is free of all symptoms for 2 years, and has no evidence of cardiac restriction or persistent pericardial effusion, is disqualifying.

A3.14.12. Current persistent tachycardia (785.1) (resting pulse rate of 100 beats per minute or greater) regardless is disqualifying.

A3.14.13. Current or history of congenital anomalies of heart and great vessels (746), except for corrected patent ductus arteriosus, are disqualifying.

**A3.15. Vascular System.**

A3.15.1. Current or history of abnormalities of the arteries and blood vessels (447), including, but not limited to aneurysms (442), atherosclerosis (440), or arteritis (446), are disqualifying.

A3.15.2. Current or history of hypertensive vascular disease (401) is disqualifying. Elevated blood pressure defined as the average of three consecutive sitting blood pressure measurements separated by at least 10 minutes, diastolic greater than 90 mmHg or systolic greater than 140 mmHg, is disqualifying (796.2).

A3.15.3. Current or history of peripheral vascular disease (443), including, but not limited to diseases such as Raynaud's Disease (443.0), is disqualifying.

A3.15.4. Current or history of venous diseases, including, but not limited to recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454), is disqualifying.

**A3.16. Blood and Blood-Forming Tissues.**

A3.16.1. Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction, is disqualifying. For the purposes of the instruction, anemia is defined as a hemoglobin of less than 13.5 for males and less than 12 for females. Use the following ICD-9 codes for diagnosed anemia: hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).

A3.16.2. Current or history of coagulation defects (286) to include, but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), Henoch-Schonlein Purpura (287.0), is disqualifying.

A3.16.3. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0) is disqualifying.

**A3.17. Abdominal Organs and Gastrointestinal System.**

A3.17.1. Current or history of esophageal disease, including, but not limited to ulceration, varices, fistula, achalasia, or Gastro-Esophageal Reflux Disease (GERD) (530.81), or complications from GERD including stricture, or maintenance on acid suppression medication, or other dysmotility disorders; chronic, or recurrent esophagitis (530.1), is disqualifying. Current or history of reactive airway disease associated with GERD is disqualifying. Current or history of dysmotility disorders, chronic, or

recurrent esophagitis (530) is disqualifying. History of surgical correction for GERD within six months is disqualifying. (P42 esophageal correction, P43 stomach correction and P45 intestinal correction.)

A3.17.2. Stomach and duodenum.

A3.17.2.1. Current gastritis, chronic or severe (535), or non-ulcerative dyspepsia that requires maintenance medication is disqualifying.

A3.17.2.2. Current ulcer of the stomach or duodenum confirmed by x-ray or endoscopy (533) is disqualifying.

A3.17.2.3. History of surgery for peptic ulceration or perforation is disqualifying.

A3.17.3. Small and Large intestine.

A3.17.3.1. Current or history of inflammatory bowel disease, including, but not limited to unspecified (558.9), regional enteritis or Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556), is disqualifying.

A3.17.3.2. Current or history of intestinal malabsorption syndromes, including, but not limited to post-surgical and idiopathic (579), is disqualifying. Lactase deficiency is disqualifying only if of sufficient severity to require frequent intervention, or to interfere with normal function.

A3.17.3.3. Current or history of gastrointestinal functional and motility disorders within the past 2 years, including, but not limited to pseudo-obstruction, megacolon, history of volvulus, or chronic constipation and/or diarrhea (787.91), regardless of cause persisting or symptomatic in the past 2 years, is disqualifying.

A3.17.3.4. History of gastrointestinal bleeding (578), including positive occult blood (792.1) if the cause has not been corrected, is disqualifying. Meckel's diverticulum (751.0), if surgically corrected greater than 6 months prior, is not disqualifying.

A3.17.3.5. Current or history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention or to interfere with normal function is disqualifying.

A3.17.3.6. History of bowel resection is disqualifying.

A3.17.3.7. Current symptomatic diverticular disease of the intestine is disqualifying.

A3.17.4. Hepatic-Biliary Tract.

A3.17.4.1. Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding 6 months, or persistence of symptoms after 6 months, or objective evidence of impairment of liver function is disqualifying.

A3.17.4.2. Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3) is disqualifying.

A3.17.4.3. Current or history of symptomatic cholecystitis, acute or chronic, with or without cholelithiasis (574); postcholecystectomy syndrome, or other disorders of the gallbladder and biliary system (576) is disqualifying. Cholecystectomy is not disqualifying if performed greater than 6 months prior to examination and patient remains asymptomatic. Fiberoptic procedure to correct sphincter dysfunction or cholelithiasis if performed greater than 6 months prior to examination and patient remains asymptomatic may not be disqualifying.

A3.17.4.4. Current or history of pancreatitis, acute (577.0) or chronic (577.1), is disqualifying.

A3.17.4.5. Current or history of metabolic liver disease, including, but not limited to hemochromatosis (275.0), Wilson's disease (275.1), alpha-1 anti-trypsin deficiency (277.6), is disqualifying.

A3.17.4.6. Current enlargement of the liver from any cause (789.1) is disqualifying.

A3.17.5. Anorectal.

A3.17.5.1. Current anal fissure or anal fistula (565) is disqualifying.

A3.17.5.2. Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6) within the last 2 years is disqualifying.

A3.17.5.3. Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last 60 days, is disqualifying.

A3.17.6. Spleen.

A3.17.6.1. Current splenomegaly (789.2) is disqualifying.

A3.17.6.2. History of splenectomy (P41.5) is disqualifying, except when resulting from trauma.

A3.17.7. Abdominal wall.

A3.17.7.1. Current hernia, including, but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553), are disqualifying.

A3.17.7.2. History of open or laparoscopic abdominal surgery during the preceding 6 months (P54) is disqualifying.

A3.17.7.3. History of any gastrointestinal procedure for the control of obesity is disqualifying. Artificial openings, including, but not limited to ostomy (V44), are disqualifying.

**A3.18. Female Genitalia and Reproductive Organs** (Also, see paragraph **A3.32.**)

A3.18.1. Urethra. (Also, see paragraph **A3.34.10.**)

A3.18.2. Cervix, Uterus, and Adnexa.

A3.18.2.1. Current or history of abnormal uterine bleeding (626.2), including, but not limited to menorrhagia, metrorrhagia or polymenorrhea is disqualifying.

A3.18.2.2. Current unexplained amenorrhea (626.0) is disqualifying.

A3.18.2.3. Current or history of dysmenorrhea (625.3) that is incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities is disqualifying.

A3.18.2.4. Current or history of endometriosis (617) is disqualifying.

A3.18.2.5. Current or history of ovarian cyst(s) (620.2) when persistent or symptomatic is disqualifying.

A3.18.2.6. Current pelvic inflammatory disease (614) or history of recurrent pelvic inflammatory disease is disqualifying.

A3.18.2.7. Current or history of chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9) is disqualifying.

A3.18.2.8. Current pregnancy (V22) is disqualifying until 6 months after the end of the pregnancy.

A3.18.2.9. History of congenital uterine absence (752.3) is disqualifying.

A3.18.2.10. Current uterine enlargement due to any cause (621.2) is disqualifying.

A3.18.2.11. Currently abnormal gynecologic cytology, including, but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding Human Papilloma Virus (079.4), or confirmed Low-Grade Squamous Intraepithelial Lesion (622.9), is disqualifying. For the purposes of this instruction, confirmation is by colposcopy or repeat cytology.

A3.18.3. Vagina and Vulva.

A3.18.3.1. Current or history of genital infection or ulceration, including, but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity requiring frequent intervention or to interfere with normal function, is disqualifying.

A3.18.3.2. History of major abnormalities or defects of the genitalia such as change of sex (P64.5), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7) is disqualifying.

**A3.19. Male Genitalia.**

A3.19.1. Penis and Urethra (Also, see paragraph **A3.34.10.**).

A3.19.1.1. History of penis amputation (878.0) is disqualifying.

A3.19.1.2. Current epispadias (752.62) or hypospadias (752.61), when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction, is disqualifying.

A3.19.1.3. Current or history of genital infection or ulceration, including, but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11) if of sufficient severity to require frequent intervention or to interfere with normal function, is disqualifying.

A3.19.1.4. History of major abnormalities or defects of the genitalia such as change of sex (P64.5), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7) is disqualifying.

A3.19.2. Testicles and Prostate: (Also, see paragraph **A3.32.**)

A3.19.2.1. Current absence of one or both testicles, congenital (752.89) or undescended (752.51), is disqualifying.

A3.19.2.2. Current enlargement or mass of testicle or epididymis (608.9) is disqualifying.

A3.19.2.3. Current orchitis or epididymitis (604.90) is disqualifying.

A3.19.2.4. Current acute prostatitis (601.0) or chronic prostatitis (601.1) is disqualifying.

A3.19.2.5. Current hydrocele (603), if large or symptomatic, is disqualifying.

A3.19.2.5.1. Left varicocele (456.4), if symptomatic, or associated with testicular atrophy, or varicocele larger than the testis, is disqualifying.

A3.19.2.5.2. Any right varicocele is disqualifying.

A3.19.2.6. Current or history of chronic scrotal pain or unspecified symptoms associated with male genital organs (608.9) is disqualifying.

**A3.20. Urinary System.** (Also, see paragraphs **A3.28.** and **A3.32.**).

A3.20.1. Current cystitis, or history of chronic or recurrent cystitis (595) is disqualifying.

A3.20.2. Current urethritis, or history of chronic or recurrent urethritis (597.80) is disqualifying.

A3.20.3. History of enuresis (788.30) or incontinence of urine (788.30) after 13th birthday is disqualifying.

A3.20.4. Current hematuria (599.7), pyuria, or other findings indicative of urinary tract disease (599) is disqualifying.

A3.20.5. Current urethral stricture (598) or fistula (599.1) is disqualifying.

A3.20.6. Kidney.

A3.20.6.1. Current absence of one kidney, congenital (753.0) or acquired (V45.73), is disqualifying.

A3.20.6.2. Current pyelonephritis (590.0) (chronic or recurrent), or any other unspecified infections of the kidney (590.9) is disqualifying.

A3.20.6.3. Current or history of polycystic kidney (753.1) is disqualifying.

A3.20.6.4. Current or history of horseshoe kidney (753.3) is disqualifying.

A3.20.6.5. Current or history of hydronephrosis (591) is disqualifying.

A3.20.6.6. Current or history of acute (580) or chronic (582) nephritis of any type is disqualifying.

A3.20.6.7. Current or history of proteinuria (791.0) (greater than 200 mg/24 hours; or a protein to creatinine ratio greater than 0.2 in a random urine sample, if greater than 48 hours after strenuous activity) is disqualifying, unless consultation determines the condition to be benign orthostatic proteinuria.

A3.20.6.8. Current or history of urolithiasis (592) within the preceding 12 months is disqualifying. Recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time is disqualifying.

**A3.21. Neurologic.**

A3.21.1. Current or history of cerebrovascular conditions, including, but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular insufficiency, aneurysm or arteriovenous malformation (437) are disqualifying.

A3.21.2. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9) is disqualifying.

A3.21.3. Current or history of disorders of meninges, including, but not limited to cysts (349.2), is disqualifying.

A3.21.4. Current or history of degenerative and hereditodegenerative disorders, including, but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), or peripheral nerves (337), are disqualifying.

A3.21.5. History of recurrent headaches (784.0), including, but not limited to, migraines (346) and tension headaches (307.81) that interfere with normal function in the past 3 years, or of such severity to require prescription medications, are disqualifying.

A3.21.6. Head injury (854.0).

A3.21.6.1. History of head injury shall be disqualifying if associated with any of the following (Also see AFI 48-123V4 Table 1.2.1):

A3.21.6.1.1. Post-traumatic seizure(s) occurring more than 30 minutes after injury.

A3.21.6.1.2. Persistent motor or sensory deficits.

A3.21.6.1.3. Impairment of intellectual function.

A3.21.6.1.4. Alteration of personality.

A3.21.6.1.5. Unconsciousness, amnesia, or disorientation of person, place, or time of 24-hours duration or longer post-injury.

A3.21.6.1.6. Multiple fractures involving skull or face (804).

A3.21.6.1.7. Cerebral laceration or contusion (851).

A3.21.6.1.8. History of epidural, subdural, subarachnoid, or intracerebral hematoma (852).

A3.21.6.1.9. Associated abscess (326) or meningitis (958.8).

A3.21.6.1.10. Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.

A3.21.6.1.11. Focal neurologic signs.

A3.21.6.1.12. Radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

A3.21.6.1.13. Leptomeningeal cysts or Arteriovenous Fistula.

A3.21.6.2. History of moderate head injury (854.03) is disqualifying. After 2 years post-injury, applicants may be qualified if neurological consultation shows no residual dysfunction or complications (see AFI 48-123V4 Table 1.2.1). Moderate head injuries are defined as unconsciousness, amnesia, or disorientation of person, place, or time alone or in combination, of more than 1 and less than 24-hours duration post-injury, or linear skull fracture.

A3.21.6.3. History of mild head injury (854.02) is disqualifying. After 1 month post-injury, applicants may be qualified if neurological evaluation shows no residual dysfunction or complications (see AFI 48-123V4 Table 1.2.1). Mild head injuries are defined as a period of unconsciousness, amnesia, or disorientation of person, place, or time, alone or in combination of 1 hour or less post-injury.

A3.21.6.4. History of persistent post-traumatic symptoms (310.2) that interfere with normal activities or have duration of greater than 1 month is disqualifying. Such symptoms include, but are not

limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

A3.21.7. Infectious diseases of the central nervous system.

A3.21.7.1. Current or history of acute infectious processes of the central nervous system, including, but not limited to meningitis (322), encephalitis (323), or brain abscess (324), are disqualifying if occurring within 1 year before examination, or if there are residual neurological defects.

A3.21.7.2. History of neurosyphilis (094) of any form, including, but not limited to general paresis, tabes dorsalis, or meningovascular syphilis, is disqualifying.

A3.21.8. Current or history of paralysis, weakness, lack of coordination, chronic pain, or sensory disturbance or other specified paralytic syndromes (344) is disqualifying.

A3.21.9. Epilepsy occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal electroencephalogram (EEG) is disqualifying. All such applicants shall have a current neurology consultation with current EEG results (345).

A3.21.10. Chronic nervous system disorders, including, but not limited to myasthenia gravis (358.0), multiple sclerosis (340), and tic disorders (307.20)[e.g., Tourette's (307.23)] are disqualifying.

A3.21.11. Current or history of retained central nervous system shunts of all kinds are disqualifying.

A3.21.12. Current or history of narcolepsy or cataplexy (347) is disqualifying.

**A3.22. Learning, Psychiatric and Behavioral.**

A3.22.1. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (314), or Perceptual/ Learning Disorder(s) (315) is disqualifying, unless applicant can demonstrate passing academic performance and there has been no use of medication(s) in the previous 12 months.

A3.22.2. Current or history of academic skills or perceptual defects (315) secondary to organic or functional mental disorders, including, but not limited to dyslexia, that interfere with school or employment, are disqualifying. Applicants demonstrating passing academic and employment performance without utilization or recommendation of academic and/or work accommodations at any time in the previous 12 months may be qualified.

A3.22.3. Current or history of disorders with psychotic features such as schizophrenia (295), paranoid disorder (297), other and unspecified psychosis (298) is disqualifying.

A3.22.4. Current mood disorders including, but not limited to, major depression (296.2-3), bipolar (296.4-7), affective psychoses (296.8-9), depressive not otherwise specified (311), are disqualifying.

A3.22.4.1. History of mood disorders requiring outpatient care for longer than 6 months by a physician or other mental health professional (V65.40), or inpatient treatment in a hospital or residential facility is disqualifying.

A3.22.4.2. History of symptoms consistent with a mood disorder of a repeated nature that impairs school, social, or work efficiency is disqualifying.

A3.22.5. Current or history of adjustment disorders (309) within the previous 3 months is disqualifying.

A3.22.6. Current or history of conduct (312), or behavior (313) disorders is disqualifying. Recurrent encounters with law enforcement agencies, antisocial attitudes or behaviors are tangible evidence of impaired capacity to adapt to military service and as such are disqualifying.

A3.22.7. Current or history of personality disorder (301) is disqualifying. History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Armed Forces is disqualifying.

A3.22.8. Current or history of other behavior disorders is disqualifying, including, but not limited to conditions such as the following:

A3.22.8.1. Enuresis (307.6) or encopresis (307.7) after 13th birthday.

A3.22.8.2. Sleepwalking (307.4) after 13th birthday.

A3.22.8.3. Eating disorders (307.5), anorexia nervosa (307.1), bulimia (307.51), or unspecified disorders of eating (307.59) lasting longer than 3 months and occurring after 13th birthday.

A3.22.9. Any current receptive or expressive language disorder, including, but not limited to any speech impediment, stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or to repeat commands, is disqualifying.

A3.22.10. History of suicidal behavior, including gesture(s) or attempt(s) (300.9), or history of self-mutilation, is disqualifying.

A3.22.11. Current or history of anxiety disorders [anxiety (300.01), panic (300.2)] agoraphobia (300.21), social phobia (300.23), simple phobias (300.29), obsessive-compulsive (300.3), other acute reactions to stress (308), posttraumatic stress disorder (309.81) are disqualifying.

A3.22.12. Current or history of dissociative disorders, including, but not limited to hysteria (300.1), depersonalization (300.6), and other (300.8), are disqualifying.

A3.22.13. Current or history of somatoform disorders, including, but not limited to hypochondriasis (300.7) or chronic pain disorder, are disqualifying.

A3.22.14. Current or history of psychosexual conditions (302), including, but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias, are disqualifying.

A3.22.15. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305), or other drug abuse (305.2 thru 305.9) is disqualifying.

A3.22.16. Current or history of other mental disorders (all 290-319 not listed above) that in the opinion of the civilian or military provider shall interfere with, or prevent satisfactory performance of military duty are disqualifying.

**A3.23. Upper Extremities** (See **paragraph A3.25.**).

A3.23.1. Limitation of motion. Current joint ranges of motion less than the measurements listed in paragraphs below are disqualifying.

A3.23.1.1. Shoulder (726.1).

A3.23.1.1.1. Forward elevation to 90 degrees.

A3.23.1.1.2. Abduction to 90 degrees.

A3.23.1.2. Elbow (726.3).

A3.23.1.2.1. Flexion to 100 degrees.

A3.23.1.2.2. Extension to 15 degrees.

A3.23.1.3. Wrist (726.4). A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.

A3.23.1.4. Hand (726.4).

A3.23.1.4.1. Pronation to 45 degrees.

A3.23.1.4.2. Supination to 45 degrees.

A3.23.1.5. Fingers and Thumb (726.4). Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

A3.23.2. Hand and fingers.

A3.23.2.1. Current absence of the distal phalanx of either thumb (885) is disqualifying.

A3.23.2.2. Current absence of distal and middle phalanx of an index, middle or ring finger of either hand irrespective of the absence of little finger (886) is disqualifying.

A3.23.2.3. Current absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand (886) is disqualifying.

A3.23.2.4. Current absence of hand or any portion thereof (887) is disqualifying, except for specific absence of fingers, as noted above.

A3.23.2.5. Current polydactyly (755.0) is disqualifying.

A3.23.2.6. Current intrinsic paralysis or weakness of upper limbs, including nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar and radial nerve (354) sufficient to produce physical findings in the hand, such as muscle atrophy and weakness is disqualifying.

A3.23.3. Current disease, injury, or congenital condition with residual weakness or symptoms such as to prevent satisfactory performance of duty, including, but not limited to chronic joint pain: shoulder (719.41), upper arm (719.42), forearm (719.43), and hand (719.44), late effect of fracture of the upper extremities (905.2), late effect of sprains without mention of injury (905.7), and late effects of tendon injury (905.8), is disqualifying.

**A3.24. Lower Extremities** (see **paragraph A3.25.**).

A3.24.1. Limitation of motion. Current joint ranges of motion less than the measurements listed in the subparagraphs below are disqualifying.

A3.24.1.1. Hip (due to disease (726.5) or injury (905.2).

A3.24.1.1.1. Flexion to 90 degrees.

A3.24.1.1.2. No demonstrable flexion contracture.

A3.24.1.1.3. Extension to 10 degrees (beyond 0 degrees).

A3.24.1.1.4. Abduction to 45 degrees.

A3.24.1.1.5. Rotation 60 degrees (internal and external combined).

A3.24.1.2. Knee (due to disease (726.6) or injury (905.4).

A3.24.1.2.1. Full extension to 0 degrees.

A3.24.1.2.2. Flexion to 110 degrees.

A3.24.1.3. Ankle (due to disease (726.7) or injury (905.4) or congenital).

A3.24.1.3.1. Dorsiflexion to 10 degrees.

A3.24.1.3.2. Plantar flexion to 30 degrees.

A3.24.1.3.3. Subtalar eversion and inversion totaling five degrees (due to disease (726.7) or injury (905.4) or congenital defect).

A3.24.2. Foot and ankle.

A3.24.2.1. Current absence of a foot or any portion thereof (896) is disqualifying.

A3.24.2.2. Current or history of deformities of the toes (acquired (735) or congenital (755.66), including, but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidicus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), overriding toe(s) (735.8), that prevents the proper wearing of military footwear or impairs walking, marching, running, or jumping, are disqualifying.

A3.24.2.3. Current or history of clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or impairs walking, marching, running, or jumping is disqualifying.

A3.24.2.4. Current symptomatic pes planus [(acquired (734), congenital (754.6)] or history of pes planus corrected by prescription custom orthotics is disqualifying.

A3.24.2.5. Current ingrown toenails (703.0), if infected or symptomatic, are disqualifying.

A3.24.2.6. Current plantar fasciitis (728.71) is disqualifying.

A3.24.2.7. Current neuroma (355.6) that is refractory to medical treatment, or impairs walking, marching, running, or jumping, or prevents the proper wearing of military footwear, is disqualifying.

A3.24.3. Leg, knee, thigh, and hip.

A3.24.3.1. Current loose or foreign body in the knee joint (717.6) is disqualifying.

A3.24.3.2. History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury is disqualifying. History of surgical correction of knee ligaments (P81.4) is disqualifying only if symptomatic or unstable.

A3.24.3.3. Current symptomatic medial and lateral collateral ligament injury is disqualifying.

A3.24.3.4. Current symptomatic medial or lateral meniscal injury is disqualifying.

A3.24.3.5. Current unspecified internal derangement of the knee (717.9) is disqualifying.

A3.24.3.6. Current or history of congenital dislocation of the hip (754.3) , osteochondritis of the hip (Legg-Perthes disease) (732.1), or slipped femoral epiphysis of the hip (732.2) is disqualifying.

A3.24.3.7. Current or history of hip dislocation (835) within 2 years preceding examination is disqualifying.

A3.24.3.8. Current osteochondritis of the tibial tuberosity (Osgood-Schlatter's disease) (732.4) is disqualifying if symptomatic.

A3.24.4. General.

A3.24.4.1. Current deformities, disease, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), ankle and/or foot (719.47) that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty, are disqualifying.

A3.24.4.2. Current leg-length discrepancy resulting in a limp (736.81) is disqualifying.

**A3.25. Miscellaneous Conditions of the Extremities** (See also **paragraphs A3.23.** and **A3.24.**).

A3.25.1. Current or history of chondromalacia (717.7), including, but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome, chronic osteoarthritis (715.3) or traumatic arthritis (716.1), is disqualifying.

A3.25.2. Current joint dislocation if unreduced, or history of recurrent dislocations of any major joint such as shoulder (831), hip (835), elbow (832), knee (836), ankle (837) or instability of any major joint [(shoulder (718.81), elbow (718.82), hip (718.85), ankle and foot (718.87) or multiple sites (718.89)] is disqualifying. History of recurrent instability of the knee or shoulder is disqualifying.

A3.25.3. Current or history of chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree that has interfered with the following of a physically active vocation in civilian life, or that prevents the satisfactory performance of military duty is disqualifying.

A3.25.4. Fractures.

A3.25.4.1. Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture) is disqualfying.

A3.25.4.2. Current retained hardware that is symptomatic, interferes with proper wearing of protective equipment or military uniform, and/or is subject to easy trauma, is disqualifying (V53.7). Retained hardware (including plates, pins, rods, wires, or screws used for fixation) is not disqualifying if fractures are healed, ligaments are stable, there is no pain, and it is not subject to easy trauma.

A3.25.5. Current devices, including, but not limited to silastic or titanium, implanted to correct orthopedic abnormalities (V43), are disqualifying.

A3.25.6. Current or history of contusion of bone or joint; an injury of more than a minor nature that shall interfere or prevent performance of military duty, or shall require frequent or prolonged treatment without fracture nerve injury, open wound, crush or dislocation, which occurred in the preceding 6 weeks [upper extremity (923), lower extremity (924), or ribs and clavicle (922)]is disqualifying.

A3.25.7. History of joint replacement of any site (V43.6) is disqualifying.

A3.25.8. Current or history of muscular paralysis, contracture, or atrophy (728), if progressive or of sufficient degree to interfere with or prevent satisfactory performance of military duty, or shall require frequent or prolonged treatment, is disqualifying.

A3.25.9. Current or history of osteochondromatosis or multiple cartilanginous exostoses (727.82) are disqualifying.

A3.25.10. Current osteoporosis (733) is disqualifying.

A3.25.11. Current osteomyelitis (730.0) or history of recurrent osteomyelitis is disqualifying.

A3.25.12. Current osteochondritis desiccans (732.7) is disqualifying.

**A3.26. Spine and Sacroiliac Joints** (see **paragraph A3.25.**).

A3.26.1. Current or history of ankylosing spondylitis or other inflammatory spondylopathies (720) is disqualifying (see **paragraph A3.25.**).

A3.26.2. Current or history of any condition, including, but not limited to the spine or sacroiliac joints, with or without objective signs that:

A3.26.2.1. Prevents the individual from successfully following a physically active vocation in civilian life (724), or that is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion is disqualifying.

A3.26.2.2. Requires external support is disqualifying.

A3.26.2.3. Requires limitation of physical activity or frequent treatment is disqualifying.

A3.26.3. Current deviation or curvature of spine (737) from normal alignment, structure, or function is disqualifying if:

A3.26.3.1. It prevents the individual from following a physically active vocation in civilian life.

A3.26.3.2. It interferes with the proper wearing of a uniform or military equipment.

A3.26.3.3. It is symptomatic.

A3.26.3.4. There is lumbar scoliosis greater than 20 degrees, thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 55 degrees when measured by the Cobb method.

A3.26.4. History of congenital fusion (756.15) involving more than two vertebral bodies is disqualifying. Any surgical fusion of spinal vertebrae (P81.0) is disqualifying.

A3.26.5. Current or history of fracture or dislocation of the vertebra (805) is disqualifying. A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

A3.26.6. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by x-ray or kyphosis is disqualifying.

A3.26.7. Current herniated nucleus pulposus (722) or history of surgery to correct is disqualifying.

A3.26.8. Current or history of spina bifida (741) when symptomatic, there is more than one vertebral level involved or with dimpling of the overlying skin is disqualifying. History of surgical repair of spina bifida is disqualifying.

A3.26.9. Current or history of spondylolysis [congenital (756.11), acquired (738.4)] and spondylolisthesis [congenital (756.12) or acquired (738.4)] are disqualifying.

**A3.27. Scapulae, Clavicles, and Ribs** (see **paragraph A3.25.**).

**A3.28. Skin and Cellular Tissues.**

A3.28.1. Current diseases of sebaceous glands to include severe acne (706.1), if extensive involvement of the neck, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of military equipment are disqualifying. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (Accutane(r)), are disqualified until eight weeks after completion of therapy.

A3.28.2. Current or history of atopic dermatitis (691) or eczema (692) after the 9th birthday is disqualifying.

A3.28.3. Current or history of contact dermatitis (692.4), especially involving materials used in any type of required protective equipment is disqualifying.

A3.28.4. Cysts.

A3.28.4.1. Current cyst (706.2), (other than pilonidal cyst), of such a size or location as to interfere with the proper wearing of military equipment is disqualifying.

A3.28.4.2. Current pilonidal cyst (685) evidenced by the presence of a tumor mass or a discharging sinus is disqualifying. Surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative is disqualifying.

A3.28.5. Current or history of bullous dermatoses (694), including, but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa, is disqualifying.

A3.28.6. Current chronic lymphedema (457.1) is disqualifying.

A3.28.7. Current or history of furunculosis or carbuncle (680) if extensive, recurrent, or chronic is disqualifying.

A3.28.8. Current or history of severe hyperhidrosis of hands or feet (780.8) is disqualifying.

A3.28.9. Current or history of congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation, is disqualifying. History of Dysplastic Nevus Syndrome is disqualifying (232).

A3.28.10. Current or history of keloid formation (701.4), if that tendency is marked or interferes with the proper wearing of military equipment is disqualifying.

A3.28.11. Current lichen planus (697.0) is disqualifying.

A3.28.12. Current or history of neurofibromatosis (Von Recklinghausen's Disease) (237.7) is disqualifying.

A3.28.13. History of photosensitivity (692.72), including, but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus is disqualifying.

A3.28.14. Current or history of psoriasis (696.1) is disqualifying.

A3.28.15. Current or history of radiodermatitis (692.82) is disqualifying.

A3.28.16. Current or history of extensive scleroderma (710.1) (see **paragraph A3.33.**) is disqualifying.

A3.28.17. Current or history of chronic or recurrent urticaria (708.8) is disqualifying.

A3.28.18. Current symptomatic plantar wart(s) (078.19) is disqualifying.

A3.28.19. Current scars (709.2), or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of military clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty, is disqualifying.

A3.28.20. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties, are disqualifying (See also **A3.33.23.**).

**A3.29. Endocrine and Metabolic.**

A3.29.1. Current or history of adrenal dysfunction (255) is disqualifying.

A3.29.2. Current or history of diabetes mellitus (250) is disqualifying.

A3.29.3. Current or history of pituitary dysfunction (253) is disqualifying.

A3.29.4. Current or history of gout (274) is disqualifying.

A3.29.5. Current or history of hyperparathyroidism (252.0) or hypoparathyroidism (252.1) is disqualifying.

A3.29.6. Thyroid disorders.

A3.29.6.1. Current goiter (240) is disqualifying.

A3.29.6.2. Current hypothyroidism (244) uncontrolled by medication is disqualifying.

A3.29.6.3. Current or history of hyperthyroidism (242.9) is disqualifying.

A3.29.6.4. Current thyroiditis (245) is disqualifying.

A3.29.7. Current nutritional deficiency diseases, including, but not limited to beriberi (265), pellagra (265.2), and scurvy (267), are disqualifying.

A3.29.8. Current persistent Glycosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4), is disqualifying.

A3.29.9. Current or history of Acromegaly, including, but not limited to gigantism, or other disorders of pituitary function (253), is disqualifying.

**A3.30. Height.** The cause for rejection for Air Force male applicants is height less than 60 inches or more than 80 inches. The cause for rejection for Air Force female applicants is height less than 58 inches or more than 80 inches.

**A3.31. Weight.** Body composition measurements may be used as the final determinant in evaluating an applicant's acceptability. For AF applicants who exceed the weight in relation to height which is prescribed in **Attachment 4**. Body fat standards will apply as outlined in **Attachment 4**.

**A3.32. Tumors and Malignancies.**

A3.32.1. Current benign tumors (M8000) or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome, are disqualifying.

A3.32.2. Current or history of malignant tumors (V10) is disqualifying. Skin cancer (other than malignant melanoma) removed with no residual, is not disqualifying.

**A3.33. Systemic.**

A3.33.1. Current or history of disorders involving the immune mechanism including immunodeficiencies (279) is disqualifying. Presence of Human Immunodeficiency Virus (HIV) or serologic evidence of infection (042) is disqualifying. Positive Enzyme-Linked Immunoabsorbent Assay test(s) for HIV with ambiguous or inconclusive results on Western Blot testing is disqualifying.

A3.33.2. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9) is disqualifying.

A3.33.3. Current or history of progressive systemic sclerosis (710.1), including CRST Variant, is disqualifying. A single plaque of localized Scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

A3.33.4. Current or history of Reiter's disease (099.3) is disqualifying.

A3.33.5. Current or history of rheumatoid arthritis (714.0) is disqualifying.

A3.33.6. Current or history of Sjogren's syndrome (710.2) is disqualifying.

A3.33.7. Current or history of vasculitis, including, but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behcet's (136.1), and Wegner's granulomatosis (446.4), is disqualifying.

A3.33.8. Tuberculosis (010).

A3.33.8.1. Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years, is disqualifying.

A3.33.8.2. Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty are disqualifying.

A3.33.8.3. Individuals with a past history of active tuberculosis greater than 2 years before appointment, enlistment, or induction are qualified if they have received a complete course of standard chemotherapy for tuberculosis.

A3.33.8.4. Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest x-ray) (795.5) is disqualifying.

***NOTE:*** Individuals with a tuberculin reaction in accordance with the guidelines of the American Thoracic Society and U.S. Public Health Service (ATS/USPHS), and without evidence of residual disease in pulmonary or non-pulmonary sites are eligible for enlistment, induction, and appointment, provided they have received chemoprophylaxis in accordance with the guidelines of the ATS/USPHS.

A3.33.9. Current untreated syphilis is disqualifying (097).

A3.33.10. History of anaphylaxis (995.0), including, but not limited to idiopathic and exercise-induced; anaphylaxis to venom, including stinging insects (989.5); foods or food additives (995.60-69); or to natural rubber latex (989.82), is disqualifying.

A3.33.11. Current residual of tropical fevers, including, but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty, is disqualifying.

A3.33.12. Current sleep disturbances (780.5), including, but not limited to sleep apneas, is disqualifying.

A3.33.13. History of malignant hyperthermia (995.86) is disqualifying.

A3.33.14. History of industrial solvent or other chemical intoxication (982) with sequelae is disqualifying.

A3.33.15. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years is disqualifying.

A3.33.16. History of rheumatic fever (390) is disqualifying.

A3.33.17. Current or history of muscular dystrophies (359) or myopathies is disqualifying.

A3.33.18. Current or history of amyloidosis (277.3) is disqualifying.

A3.33.19. Current or history of eosinophilic granuloma (277.8) is disqualifying. Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, shall not be a cause for disqualification. All other forms of the histiocytosis (202.3) are disqualifying.

A3.33.20. Current or history of polymyositis (710.4)/dermatomyositis complex (710.3) with skin involvement is disqualifying.

A3.33.21. History of rhabdomyolysis (728.88) is disqualifying.

A3.33.22. Current or history of sarcoidosis (135) is disqualifying.

A3.33.23. Current systemic fungus infections (117) are disqualifying (See also **A3.28.20.**).

**A3.34. Miscellaneous.**

A3.34.1. Current or history of parasitic diseases, if symptomatic or carrier state, including, but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), unspecified infectious and parasitic disease (136.9), are disqualifying.

A3.34.2. Current or history of other disorders, including, but not limited to cystic fibrosis (277.0), or porphyria (277.1), that prevent satisfactory performance of duty or require frequent or prolonged treatment are disqualifying.

A3.34.3. Current or history of cold-related disorders, including, but not limited to frostbite, chilblain, immersion foot (991), or cold uritcaria (708.2), are disqualifying. Current residual effects of cold-related disorders, including, but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, anklylosis, trench foot, or deep-seated ache, are disqualifying.

A3.34.4. History of angioedema, including hereditary angioedema (277.6), is disqualifying.

A3.34.5. History of receiving organ or tissue transplantation (V42) is disqualifying.

A3.34.6. History of pulmonary (415) or systemic embolization (444) is disqualifying.

A3.34.7. History of untreated acute or chronic metallic poisoning, including, but not limited to lead, arsenic, silver (985), beryllium, or manganese (985), is disqualifying. Current complications or residual symptoms of such poisoning are disqualifying.

A3.34.8. History of heat pyrexia (992), heatstroke (992.0), or sunstroke (992.0) is disqualifying. History of three or more episodes of heat exhaustion (992.3) is disqualifying. Current or history of a predisposition to heat injuries, including disorders of sweat mechanism, combined with a previous serious episode is disqualifying. Current or history of any unresolved sequelae of heat injury, including, but not limited to nervous, cardiac, hepatic or renal systems, is disqualifying.

A3.34.9. Current or history of any condition that in the opinion of the medical officer shall significantly interfere with the successful performance of military duty or training is disqualifying (should use specific ICD code whenever possible, or 796.9).

A3.34.10. Any current acute pathological condition, including, but not limited to acute communicable diseases, until recovery has occurred without sequelae, is disqualifying.

## Attachment 4

## WEIGHT LIMITS FOR ACCESSION – MALE AND FEMALE

**Table A4.1. Height and Weight Tables for Accession.**

| Height (inches) | (pounds) | |
|---|---|---|
| | Minimum (BMI = 19 kg/m) | Maximum (BMI = 27.5 kg/m) |
| 58 | 91 | 131 |
| 59 | 94 | 135 |
| 60 | 97 | 141 |
| 61 | 100 | 145 |
| 62 | 104 | 150 |
| 63 | 107 | 155 |
| 64 | 110 | 160 |
| 65 | 114 | 165 |
| 66 | 117 | 170 |
| 67 | 121 | 175 |
| 68 | 125 | 180 |
| 69 | 128 | 186 |
| 70 | 132 | 191 |
| 71 | 136 | 197 |
| 72 | 140 | 202 |
| 73 | 144 | 208 |
| 74 | 148 | 214 |
| 75 | 152 | 220 |
| 76 | 156 | 225 |
| 77 | 160 | 231 |
| 78 | 164 | 237 |
| 79 | 168 | 244 |
| 80 | 173 | 250 |

***NOTES:***

1. In accordance with AFI 10-248, *Fitness Program,* chapter 6.1, weight and body fat determination (as accomplished at MEPS or other point of entry to the service) remain part of accession physical standards and may also be used as entry criteria for accession training programs.

2. If an applicant exceeds the listed maximum weight standards, then body fat measurement (BFM) will be performed as described in DODI 1308.3, To qualify for entry, a male BFM can be no more than 20% and female BFM, no more than 28% for ages up to 30 years. At age 30 and older the body fat limit is no more than 24% for males and 32% for females.
3. If the applicant passes the BFM, processing can continue, and if during subsequent processing the applicant's weight is found to be at or below the maximum weight standard, no further BFM is required.
4. If the initial BFM exceeds standards, the applicant will be temporarily disqualified until such time that either the maximum weight standard or BFM is met to continue processing.
5. Maximum weight standards and BFM, if applicable, are used only as accession standards. Once accessed, members will be managed according to their fitness score IAW AFI 10-248. For all cross-training and entry to special duty programs, i.e., flying training programs, individuals must complete all four components of the fitness test and have a composite score of 75 or greater. See AFI 48-123V3 Attachment 4.30. for additional requirements for flying applicants.
6. Applicants who fall below the minimum weight standards shall be referred for medical evaluation. If no disqualifying causes are found as described in **Attachment 2** of this instruction, a waiver may be considered by Air Education and Training Command (AETC)/SGPS. For ARC, see AFI 48-123V4, Table A2.1.